NAVAL POSTGRADUATE SCHOOL
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THESIS

ANALYSIS OF THE SELECTION PROCESS FOR EXECUTIVE MANAGEMENT POSITIONS AT NAVY MEDICAL/DENTAL TREATMENT FACILITIES

by

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and

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March 2001

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This study describes, analyzes and compares Navy Medicine's command screening process. Organizational structure and behavioral models, and public policy models are used to explain the process and to provide the theoretical framework for the study. Twenty-one semi-structured interviews were conducted with senior stakeholders involved in the process. A written questionnaire was developed to assess the knowledge and perceptions of Navy Medical Department Captains. One hundred forty-six survey responses were obtained which showed: the overall process is perceived to be *fair* and *objective* and meets the needs of Navy Medicine; *self-exemption* from selection is an *acceptable* part of the process; the "best record" is selected; and respondents are *familiar* with the process. Some knowledge deficiencies were uncovered, i.e., who serves on the board, and length of time individuals remain in the screened pool. Candidates' primary reasons for seeking command assignments were to improve Navy Medicine, obtain increased responsibility, and personal satisfaction. Recommendations include: continue improving communications between decision makers and prospective candidates; prepare, groom and select officers earlier in the process; and improve fitness report accuracy in terms of describing actual performance and potential for command.

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ANALYSIS OF THE SELECTION PROCESS FOR EXECUTIVE MANAGEMENT POSITIONS AT NAVY MEDICAL/DENTAL TREATMENT FACILITIES

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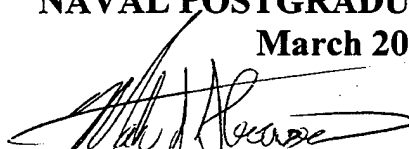
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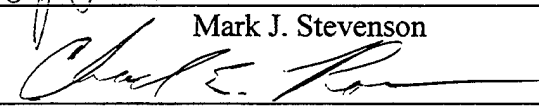requirements for the degree of

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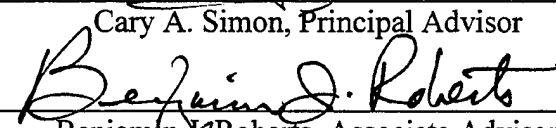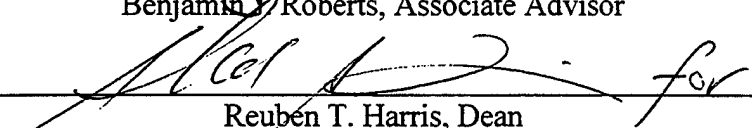## NAVAL POSTGRADUATE SCHOOL
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ABSTRACT

This study describes, analyzes and compares Navy Medicine's command screening process. Organizational structure and behavioral models, and public policy models are used to explain the process and to provide the theoretical framework for the study. Twenty-one semi-structured interviews were conducted with senior stakeholders involved in the process. A written questionnaire (Likert-scaled and closed-ranking) was developed to assess the knowledge and perceptions of Navy Medicine Captains (n = 146). Statistically significant survey responses were obtained. Results showed the following: the overall process is perceived to be *fair* and *objective* and meets the needs of Navy Medicine; *self-exemption* from selection is an *acceptable* part of the process and *fits* the organization's highly professional nature; the "best record" is selected; and respondents are *familiar* with the process. Some knowledge deficiencies were uncovered, i.e., who serves on the board, and length of time individuals remain in the screened pool. Candidates' primary reasons for seeking command assignments were to improve Navy Medicine, obtain increased responsibility, and personal satisfaction. Recommendations include: continue improving communications between decision makers and prospective candidates; prepare, groom and select officers earlier in the process; and improve fitness report accuracy in terms of describing actual performance and potential for command.

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LIST OF ACRONYMS

A.B.M.S.	American Board of Medical Specialists
A.D.A.	American Dental Association
AMA	American Medical Association
A.O.A.	American Osteopathy Association
AQD	Additional Qualification Designator
ASD(HA)	Assistant Secretary of Defense for Health Affairs
BUMED	Bureau of Medicine and Surgery
BUMEDINST 5430.7	Organization Manual for Naval Medical and Dental Treatment Facilities (MTFs & DTFs)
B.S.N.	Bachelor of Science in Nursing
CAPT	Captain
CDR	Commander
CEC	Civil Engineer Corps
CEO	Chief Executive Officer
CEU	Continuing Education Units
CIO	Chief Information Officer
CNATRA	Chief, Naval Air Training Command
CNO	Chief of Naval Operations
CNP	Chief of Naval Personnel
CO	Commanding Officer
COMNAVAIRLANT	Commander, Naval Air Forces Atlantic

COMNAVAIRPAC	Commander, Naval Air Forces Pacific
COO	Chief Operating Officer
COMNAVPERSCOM	Commander, Naval Personnel Command
DAS	Director for Ancillary Services
DC	Dental Corps
DCNP	Deputy Chief of Naval Personnel
DCS	Director Clinical Services
D.D.S.	Doctor of Dental Surgery
DFA	Director for Administration
DH	Department Head
D.M.D.	Doctor of Dental Medicine
DMS	Director for Medical Services
DNS	Director for Nursing Services
DoD	Department of Defense
DON	Department of the Navy
DSG	Navy Deputy Surgeon General
DSS	Director for Surgical Services
DTF	Dental Treatment Facility
EMPRIS	Electronic Military Personnel Record Information System
ENS	Ensign
ESC	Executive Steering Council
FITREP	Fitness Report

FY	Fiscal Year
GME	Graduate Medical Education
GMO	General Medical Officer
HCA	Health Care Administration
HCS	Health Care Scientist
IG	Inspector General
JAG	Judge Advocate General Corps
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JPME	Joint Professional Military Education
KDHCD	Kaweah Delta Health Care District
LCDR	Lieutenant Commander
LT	Lieutenant
LTJG	Lieutenant Junior Grade
MANDEV	Management Development Course
MANMED	Manual of the Medical Department
MBA	Masters in Business Administration
MED-00	BUMED Organizational Code for Navy Surgeon General/Chief, BUMED
MED-09	BUMED Organizational Code for Navy Deputy Surgeon General/Deputy Chief, BUMED
MED-00DC	BUMED Organizational Code for Chief, Navy Dental Corps
MED-00MC	BUMED Organizational Code for Chief, Navy Medical Corps

MED-00MSC	BUMED Organizational Code for Director, Navy Medical Service Corps
MED-00NC	BUMED Organizational Code for Director, Navy Nurse Corps
METOC	Meteorology/Oceanography
MC	Medical Corps
MHS	Military Health System
MILPERSMAN	Military Personnel Manual
MSC	Medical Service Corps
MTF	Medical Treatment Facility
N76	Office of the Chief of Naval Operations, Surface Warfare Division
NAVFAC	Naval Facilities Command
NAVPERSCOM	Navy Personnel Command
NH	Naval Hospital
NMC	Naval Medical Center
NMCL	Naval Medical Clinic
NMOC	Naval Meteorology and Oceanographic Command
NNMC	National Naval Medical Center, Bethesda, MD
NDC	Naval Dental Center
NC	Nurse Corps
NE	Nurse Executive
NLSO	Naval Legal Service Office
NOBCs	Navy Officer Billet Classification Codes

NRD	Naval Recruiting District
NSHS	Naval School of Health Sciences
NWC	Naval War College
OAIS	Officer Assignment Information System
OIC	Officer in Charge
OCONUS	Outside the Continental United States
OJAG	Office of the Judge Advocate General of the Navy
OPNAV	Office of the Chief of Naval Operations
OPNAVINST 3120.32C	Standard Organization and Regulations of the U.S. Navy
OP-093	Office of the Chief of Naval Operations, Director Navy Medicine
OSR/PSR	Officer Summary Record/Performance Summary Record
OTM	Officer Transfer Manual
PCO/PXO	Prospective Commanding Officer/Prospective Executive Officer (course)
PCS	Permanent Change of Station
PERS-4415	Head, Medical Assignments/Placement Branch, Naval Personnel Command
PERS-4415B	Head, Medical Placement, Naval Personnel Command
PERS-4415G	Head, Dental Corps Assignments, Naval Personnel Command
PERS 4415I	Head, Medical Service Corps/Health Care Administration Assignments, Naval Personnel Command

PERS 4415J	Head, Medical Service Corps/Health Care Sciences Assignments, Naval Personnel Command
PERS 4415K	Head, Nurse Corps Assignments, Naval Personnel Command
PERS 4415M	Head, Medical Corps Surgical Specialty Assignments, Naval Personnel Command
PERS-451F	Special Assistant for Selection Board Matters, Naval Personnel Command
PRD	Projected Rotation Date
RL	Restricted Line Officer
RLC	Responsible Line Commander
RN	Registered Nurse
SC	Supply Corps
SECNAV	Secretary of the Navy
SECNAVINST	Secretary of the Navy Instruction
SECNAVINST 1401.3	Selection Board Membership
SG	Navy Surgeon General
SJA	Staff Judge Advocate
SORM	Standard Organization and Regulations Manual
SSN	Attack Submarines
SSBN	Fleet Ballistic Missile Submarines
SWOT	Strengths, Weaknesses, Opportunities and Threats Analysis
TQL	Total Quality Leadership
TQM	Total Quality Management

TSO	Trial Services Office
URL	Unrestricted Line Officer
VCNO	Vice Chief of Naval Operations
VP	Vice President
VTC	Video Teleconference
XO	Executive Officer

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I. INTRODUCTION

A.   OVERVIEW

The military healthcare system (MHS) is under pressure to provide increasingly efficient and effective health and dental care to approximately eight million eligible beneficiaries.   The advent of TRICARE, Department of Defense (DoD) budgetary constraints and the complexity of managing medical treatment facilities (MTFs) and dental treatment facilities (DTFs) around the world, increases the need for talented leadership.   The thesis is about leadership, specifically the process whereby Naval officers from the four officer communities within Navy Medicine are screened and selected for Commanding Officer (CO) and Executive Officer (XO) positions.   Civilian and military healthcare professionals realize the value of having highly qualified leaders in executive and command positions.   Selecting the best leaders is critical for successful performance of MTFs and DTFs facing tough choices in a complex healthcare environment

Prior to 1989, the Navy Surgeon General (SG) selected the COs and XOs of MTFs and DTFs.   However, the Secretary of the Navy (SECNAV) and the Chief of Naval Operations (CNO) established a Department of the Navy (DON) Medical Blue Ribbon Panel in 1988 to evaluate different aspects of the Navy Medical Department.   The Panel's final report uncovered the following issue: "There are no identifiable prerequisites, career path or formal criteria to select and assign properly trained and proven personnel to leadership positions leading to command similar to ones VCNO established for COs in 1982 and XOs in 1987 for the Unrestricted Line (URL)

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community. Selection criteria is based on seniority and general experiences, but no specific training courses or prior assignments are required for selection." The Panel recommended: "Unrestricted line officer career paths provide a proven stepping stone approach that develops and hones leadership skills through ever-increasing levels of responsibility leading to command. A similar system is needed for Medical Department officers." In response to this report, a formal Medical Department command screening board was established in 1989 at the Naval Personnel Command (NAVPERSCOM), which incorporated distinguishable career paths and screening elements to identify the pool of "best qualified" officers for all Medical Department MTF/DTF CO/XO billets (Medical Department Officer Career Guide, 1991).

B.   RESEARCH SCOPE AND OBJECTIVES

This analysis includes all relevant policies and processes involved in the Medical Department command screening board to identify future COs and XOs of the twenty-two naval hospitals, five ambulatory care clinics, and fifteen dental centers located worldwide. The overall selection process is described from the perspective of four stakeholder groups: target group; decision makers; implementers; and influencers (Quade, 1989). Potential CO/XO candidates from the four officer communities within Navy Medicine (Medical Corps, Dental Corps, Medical Service Corps, and Nurse Corps) are addressed in this study as the "target group" of stakeholders (Quade, 1989). Organizational structure and behavioral models, and public policy models are used to explain the process and MTF/DTF design characteristics, and to provide the theoretical framework for this study. These models include: Mintzberg's Organizational Design Model; Elitist; Incremental; Bureaucratic-Politics; and Organizational Systems models

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(Mintzberg, 1993; Dye, 1995; Nadler & Tushman, 1991; Roberts, 2000; and Lindblom, 1995). The Medical Department command screening process is also compared to other Navy line and staff corps' selection processes, as well as civilian health care executive screening and selection.

The study describes and analyzes how the Bureau of Medicine and Surgery (BUMED) selects its current and future leadership. It answers questions concerning the efficiency of actually a series of processes used to identify and select future leaders. It draws conclusions on how effective the overall selection system is in terms of adapting to a rapidly changing post-Cold War and post-Desert Storm environment. Medical and dental officers can use the study to increase their understanding of the command selection process. The study describes the sequential steps, identifies perceived strengths and weaknesses, and provides suggestions for streamlining and improving the efficiency and effectiveness of the overall process. The research identifies the various stakeholders including their perceived level of knowledge and understanding, and makes recommendations for improvements.

C.   RESEARCH QUESTIONS

The following research questions are addressed:

1. How efficient and effective are the current Navy Medical Department command screening processes (i.e., how labor intensive and how adaptive)?
2. What models describe and explain the command screening system and processes?
3. What are the overall sequence of factors contributing to screening and selection of CO/XO positions, and how do various sub-processes relate?
4. Who are the major stakeholders in the screening and selection process and what are their roles, responsibilities, and levels of understanding?
5. What are the similarities and differences between the four officer Corps within Navy Medicine concerning screening and selection?

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6. What other factors may impact the command screening process, e.g., self-exemption of eligible candidates, level of understanding and consensus regarding equity and validity of the process?
7. How does the screening and selection process compare and contrast to the line and other Navy staff Corps?
8. How can the Navy Medical Department command screening process be improved?

D. METHODOLOGY

Three primary methods of data collection are used to answer the research questions: 1) literature model review/document analysis; 2) a written, Likert-scaled survey, and 3) semi-structured interviews with 21 senior stakeholders. Current DoD and Navy regulations, Navy Medicine doctrine, and governmental reports covering qualifications of personnel eligible for command screening are reviewed for background data. Additionally, organizational and policy models applicable to the topic are described and infused into the analysis to provide a theoretical framework. Stakeholder analysis and Strengths, Weaknesses, Opportunities, and Threats (SWOT) analyses are used as tools to describe the screening and selection process.

A written questionnaire (Likert-scaled and closed ranking) was used to ascertain stakeholders' knowledge and perceptions concerning the command screening process. The questionnaire was designed for Navy Medical Department Captains (CAPTs) and Captain selects (CAPT(select)) representing the Medical Corps (MC), Dental Corps (DC), Medical Service Corps (MSC), and Nurse Corps (NC). Interviews were conducted with the Navy Surgeon General and the Directors of the MC, DC, MSC and NC. Interviews were also conducted with various personnel involved in the command screening process as well as line officer counterparts and other staff corps career managers.

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E.   ORGANIZATION OF THE THESIS

Chapter II outlines the research methodology used during the literature search, semi-structured interviews and survey development and implementation. Chapter II also details the structure and purpose of the written questionnaire.

Chapter III discusses the models and theories applicable to the Navy Medical Department command screening process, and Chapter IV provides a detailed description of the processes, including preparation for the formal selection board through the selection of individuals for command assignments. Chapter IV also describes eight other Navy line and staff Corps' communities command selection processes, as well as civilian healthcare Chief Executive Officer (CEO) and Chief Operating Officer (COO) selection processes.

Chapter V analyzes the models and theories as they pertain to MTF's/DTF's organizational structures and the Navy Medical Department command screening process. Chapter V provides a detailed stakeholder analysis and a SWOT analysis based on interviews with senior Navy Medicine leaders. Chapter VI analyzes the target group survey results and the interviews conducted with 21 major stakeholders involved in the process.

Chapter VII contains conclusions and recommendations generated from the study and answers the research questions. Areas for improvement are addressed as well as possible areas for follow-on research.

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II. METHODOLOGY

The research methods used in this thesis concentrated on three main areas: a literature search and models review, a written, Likert-scaled survey, and personal interviews. In describing the command screening process, emphasis was placed on the personal interviews with 21 major stakeholders involved in the process since literature on the topic is limited. The three research methodologies were selected for their applicability in answering the research questions, i.e., a complex process is described from several theoretical perspectives, and tools are used to capture diverse stakeholder perceptions concerning the process.

A. LITERATURE REVIEW

Literature dealing with the Navy Medical Department's command screening process is limited, therefore the literature review concentrated on explanatory organizational behavior/structure and public policy models. Textbooks and articles describing the organizational structures, systems and configurations were examined and compared with aspects of the topic. For example, Mintzberg's (1993) professional and machine bureaucracy configurations, and Roberts (2000) Organizational Systems Framework are particularly relevant.

In researching the Medical Department command screening process, it was fundamental that the organizational mandates (laws, regulations and instructions) that impact the process be examined. Bryson (1995) notes that mandates depict what an organization must and should be accomplishing. Some of the specific documents (mandates) that have a major influence on the command screening process include: Title

10 - United States Code, Secretary of the Navy instructions (SECNAVINST) covering selection board membership, U.S. Navy Medical Department Officer Career Guide, Final Report of the Medical Blue Ribbon Panel which directed the establishment of a formal command selection board, Military Personnel Manual (MILPERSMAN), Officer Transfer Manual (OTM), BUMED Organizational Manual for Navy Medical and Dental Treatment Facilities, FY01 Command Selection Board Precept, U.S. Navy Regulations and Naval Personnel Command inter-departmental correspondence.

B.   QUESTIONNAIRE

A written, Likert-scaled questionnaire (Appendix A) was used to ascertain stakeholders' knowledge and perceptions concerning the command screening process. The questionnaire was designed for Navy Medical Department Captains (CAPTs) and Captain selects (CAPT(select)) representing the Medical Corps, Dental Corps, Medical Service Corps, and Nurse Corps.

1.   Questionnaire Development

Two literature sources were used in developing the questionnaire: *How to Conduct Surveys,* (Fink & Kosecoff, 1998), and *Asking Questions: A Practical Guide to Questionnaire Design,* (Sudman & Bradburn, 1982). Using these two sources as guides, the objective was to develop a concise questionnaire that was user-friendly to respondents and would provide quantifiable data concerning their perceptions. The questionnaire was distributed by electronic mail to 1,200 potential candidates. One hundred forty-six usable surveys were completed and analyzed.

In developing the questionnaire, several key factors were considered. First, the respondents were informed about the motive of the study, i.e., a Naval Postgraduate

School thesis to describe and improve the command screening board process. Second, the respondents were informed how to interpret the questions, and where and when to return the questionnaire. Informing the respondents on how to interpret was important because several questions required the respondents to select/rank their best three answers, and other questions required Likert-scaled responses. Participants were promised anonymity, i.e., no names are used in the thesis. All of the above factors were explained in the respondent instruction section located on the first page of the questionnaire. Another factor in developing the questionnaire involved the sequence of questions. Questions were listed in a logical order so that respondents could more easily relate to the screening and selection process.

Another factor built into the questionnaire included some questions designed to check respondents' consistency, or knowledge level in several areas. Questions asking for specific answers were purposely repeated to validate previous answers. The purpose was to assess perceptions and knowledge. Lastly, it was important to let the respondents know their efforts were greatly appreciated by ending the survey with a sincere thank you. The questionnaire was distributed to ten Medical Department CAPTs for beta testing and evaluation. When all ten were returned, comments were incorporated into the final questionnaire for electronic mail distribution.

2. **Questionnaire Distribution**

The questionnaire was distributed over a three-week time period as an attachment to electronic mail to the Directors for Administration (DFAs) and Navy Medicine CAPTs at Naval Medical Centers (NMC), Naval Hospitals (NH), Naval Dental Centers (NDC), Navy Medical Clinics (NMCL), Navy Medicine headquarters units, medical/dental units

assigned to the Marines, and medical research commands worldwide. Instructions for distribution were included in the electronic mail message. Some of the questionnaires were distributed to specific individuals, while a majority of the questionnaires were under the distribution control of the DFAs. Throughout the process, the researchers monitored the distribution to ensure that each Corps was equally represented. The fact that completion of the questionnaire was entirely voluntary, the results would remain confidential, and the questionnaire was being used in a graduate education thesis were repeated during the distribution phase. Instructions to fax the completed questionnaire back to the researchers were provided on the questionnaire.

C. INTERVIEWS

A literature review was completed prior to conducting the interviews to ensure that the researchers made best use of available time with each interviewee. The primary source used in preparing for and conducting the interviews was *Qualitative Evaluation and Research*, (Patton, 1990). Two types of interview structures were used: open-ended questions and definitive, or closed-fixed questions. The same open-ended questions were asked to all interviewees so that their responses could be analyzed and compared. A fewer number of closed-fixed questions were used where interviewees were asked the same questions, but had to choose from a list of alternatives. These two types of questions were used to obtain a richer mix of open and specific responses.

Prior to the interviews taking place, sample questions were developed and reviewed for content and time limitations. Questions were designed to ascertain the interviewee's perceptions in terms of behaviors (what the person has done or is doing), values (what the person thinks about a topic), feelings (how the person feels about a

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topic), knowledge (what the person knows), and senses (what the person has observed or heard). The researchers, in both the preparation and interview phases, adhered to several interview techniques. First, the purpose of the interview, confidentiality, format and interview length were explained to each of the participants. Permission to take notes and record the interview was also requested. The researcher's contact information was provided for any follow-on discussion and each interviewee was thanked for their time and participation. As part of the interview process, a SWOT analysis was conducted. This tool allowed the researchers to ascertain the internal strengths and weaknesses affecting the organization, as well as the external opportunities and threats facing the organization relating to the command screening process.

The interviews were conducted in two phases. The first phase took place at the Naval Personnel Command (NAVPERSCOM) in Millington, Tennessee and was designed to gain a thorough and detailed description of the formal screening and selection process of the Navy Medical Department and the other communities within the Navy. The second phase took place at the Bureau of Medicine and Surgery (BUMED), Washington, DC. All of the individuals were contacted and scheduled prior to arriving in the area.

1. Naval Personnel Command, Millington, TN

Five of the Medical Department assignment officers (detailers) and the senior medical placement officer were interviewed regarding the formal process and their roles and responsibilities in this process. Interviews were also conducted with ten senior assignment and placement officers in the aviation, Civil Engineering Corps (CEC), fleet support, Judge Advocate General (JAG) Corps, meteorology/oceanography (METOC),

submarine warfare, Supply Corps (SC), and surface warfare communities. Standardized, open-ended questions and definitive, or closed-fixed type questions were used. Responses were recorded on paper by both researchers. Notes from each interview were compared for consistency and transcribed into a summary document. A list of the interview questions used at NAVPERSCOM is included in Appendix B.

2. Bureau of Medicine and Surgery, Washington, DC

The major stakeholders impacting the Navy Medical Department command screening process were interviewed to gain in-depth information about the topic and a thorough understanding of their experiences and responsibilities in the process. Stakeholders involved in the Medical Department command screening process that were interviewed included: Navy Surgeon General, Chief Navy Medical Corps, Chief Navy Dental Corps, Director Navy Medical Service Corps, Director Navy Nurse Corps, Deputy Chief Navy Dental Corps, Deputy Director Navy Nurse Corps, and the Career Planning Officers for the Navy Medical Service Corps and Navy Medical Corps. As a lesson learned from the Millington interviews, each interview was tape-recorded. A list of the interview questions used at BUMED is included in Appendix C.

III. ORGANIZATIONAL MODELS REVIEW

A. OVERVIEW

This chapter refers to five organizational models to explain relevant aspects of medical and dental treatment facilities (MTFs/DTFs), particularly concerning the Navy Medical Department command screening process. Analytical models can simplify, clarify and explain complex relationships, and they help identify causes and consequences of public policy (Dye, 1995). This chapter summarizes the key features of these analytical models, which will be applied to Navy MTFs and DTFs, and the Navy Medical Department command screening process in Chapter V.

The first model described is Mintzberg's Organizational Model (1993), which provides an overarching structure relevant to the professional nature of MTFs and DTFs. The second model is the Systems Model, which shows organizational factors as inputs, throughputs, and results, including the external environment. The third model is the Elite Model, which suggests that the mass of people generally do not care about policy decisions, rather that the few at the apex of a society or an organization shape and enact decisions for the many. The fourth model is the Incremental Model, which views decision-making and implementation as a continuation of past activities with changes occurring incrementally at the margins. The fifth model is the Bureaucratic-Politics Model, where the context of decision-making involves stakeholders bargaining and negotiating for decisions that are politically rational.

Prior to discussing the five analytical models, the terms efficiency and effectiveness are clarified. Two analytical tools are also examined as aids for

understanding the Medical Department command screening process: Stakeholder analysis, and strengths, weaknesses, opportunities and threats (SWOT) analysis.

B.   EFFICIENCY AND EFFECTIVENESS DEFINED

The first research question was to determine if the Navy Medical Department's command screening process was efficient and effective. Webster defines efficiency as "the ability to produce a desired effect, product, etc. with a minimum of effort, expense, or waste." Pennings and Goodman (1977) emphasize that efficiency focuses on the input-output ratio. They believe that to be efficient is to do things well, and that organizations do things well by using existing knowledge, standardizing and making small incremental improvements to existing processes. Webster defines effectiveness as "that which produces a definite effect or result." Pennings and Goodman note that effectiveness is related to perceptions of the external environment, and that organizations make changes that cater to these perceptions.

Efficiency and effectiveness are both linked to organizational performance. However, since efficiency is determined by internally driven factors and effectiveness is determined by externally driven factors, the two may compete for resources. Because they compete for resources, decision-makers must determine how much balance between efficiency and effectiveness is required in their organizations (March, 1995).

C.   ANALYTICAL TOOLS

1.   Stakeholder Analysis

A valuable tool that can be used to analyze a process, or an entire organization is called a stakeholder analysis. A stakeholder analysis is used to identify an organization's internal and external stakeholders, reveal how stakeholders influence the organization

and determine how important each stakeholder is to an organization. Bryson (1995) defines stakeholder as "any person, group, or organization that can place a claim on the organization's resources, attention, or output, or is affected by its output." Using a stakeholder identification worksheet (Figure 1), internal and external stakeholders impacted by an organization are recorded and analyzed. After all relevant stakeholders have been identified; a stakeholder map can be generated (Figure 2). The stakeholder map shows that many individuals and groups can solicit an organization's attention, resources, and output (Bryson, 1995).

Another important aspect of conducting a stakeholder analysis is to ensure that all stakeholders' needs are considered carefully, especially when stakeholders are physically distant from the organization. Stakeholders assess an organization's performance from the stakeholder's perspective. By use of surveys, interviews, and focus groups, an analyst can ask stakeholders for feedback to ascertain how well they think the organization is doing (Bryson, 1995). A stakeholder analysis enables an organization to view performance from an external perspective, particularly relevant to public and military organizations that are owned and funded by the public.

Figure 1. Stakeholder Identification Worksheet

External Stakeholders

Internal Stakeholders
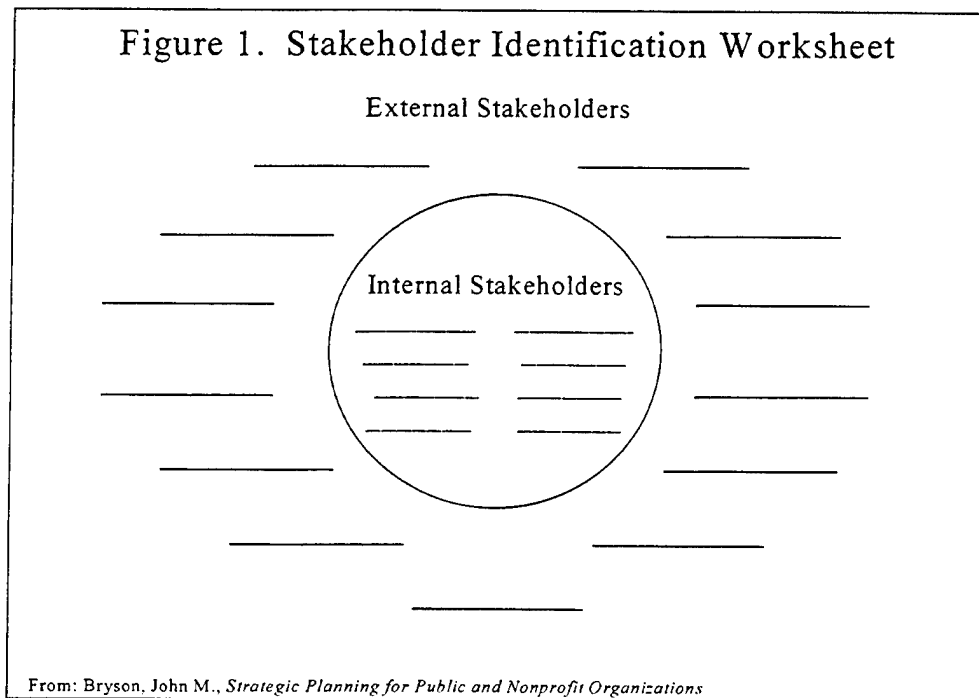
Figure 2. A Stakeholder Map for a Government

Governing Body

Political Parties

Citizens

Financial Community

Other Governments

Future Generations

Suppliers

GOVERNMENT

Interest Groups

Competitors

Media

Employees

Unions

Service Recipients

Taxpayers

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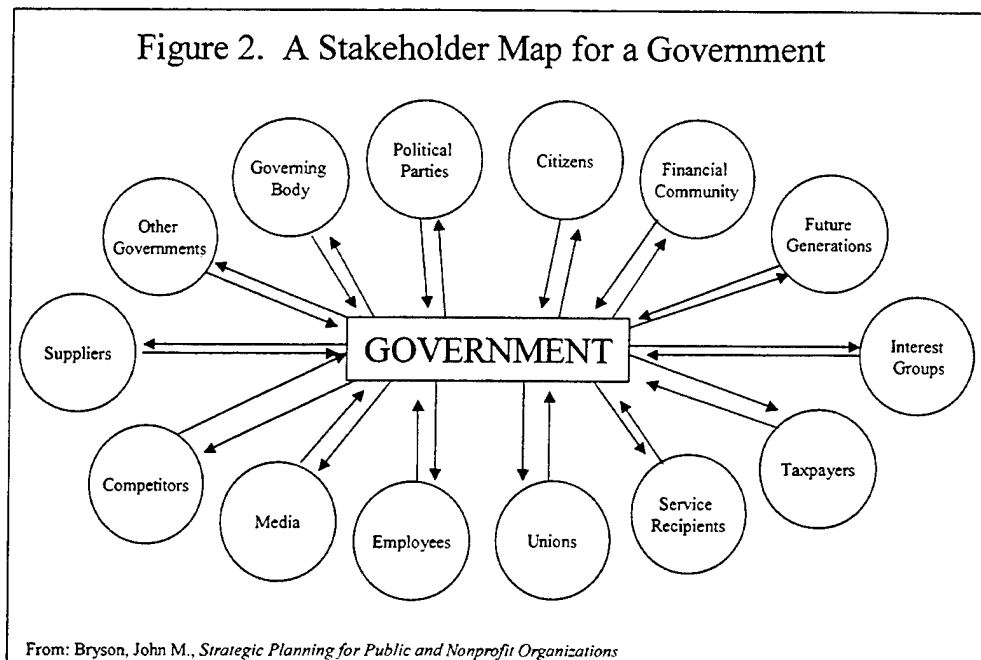
In public policy decision-making, Quade (1989) identifies four main groups of stakeholders: target group; implementers; decision-maker; and influencers. The target group is the population for whom the program or policies are intended. The implementers are the individuals and/or groups that are responsible for carrying out policy initiatives. The decision-maker develops and/or approves which policies are implemented in the organization and the influencers are the individuals and/or groups who have a direct influence on policy decisions (Quade, 1989).

2.   Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis

Organizations can be assessed in terms of their current strengths and weaknesses, and future opportunities and threats. This evaluation, referred to as a SWOT analysis, looks at internal and external environmental factors that are impacting the organization, i.e., factors that are likely to affect the implementation of present and future strategic decisions. A method of summarizing an organization's internal and external factors is through the use of a SWOT matrix (Figure 3). This matrix shows how external opportunities and threats facing an organization can be matched with an organization's internal strengths and weaknesses. In each of the four blocks, various strengths, weaknesses, opportunities and threats are listed for comparison (Wheelen, 1992).

Analyzing an organization's strengths, weaknesses, opportunities and threats is useful in clarifying the conditions impacting current and future organizational performance. The SWOT analysis supplies an overall view of the organization and the factors that affect it. A SWOT analysis should reveal the organization's advantages, what it does well, what is does not do well, what can be improved and what should be avoided. A SWOT analysis should also expose opportunities facing an organization

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including interesting trends, changes in technology and markets, as well as changes in government policy, social patterns, population profiles, and lifestyle changes. The analysis should uncover potential obstacles the organization might face, what the competition is doing, and any other threats to the organization's position or bottom line (Wheelen, 1992).

Figure 3: Generating a S.W.O.T. Matrix

INTERNAL FACTORS (IFAS) EXTERNAL FACTORS (EFAS)	Strengths (S) ---------------------------- List 5 - 10 internal strengths here	Weaknesses (W) ---------------------------- List 5 - 10 internal weaknesses here
Opportunities (O) ---------------------------- List 5 - 10 external opportunities here	SO Strategies Generate strategies here that use strengths to take advantage of opportunities	WO Strategies Generate strategies here that take advantage of opportunities by overcoming weaknesses
Threats (T) ---------------------------- List 5 - 10 external threats here	ST Strategies Generate strategies here that use strengths to avoid threats	WT Strategies Generate strategies here that minimize weaknesses and avoid threats

From: Adapted from H. Weihrich, "The TOWS Matrix - A Tool for Situational Analysis, "Long Range Planning (April 1982)

D. MINTZBERG'S ORGANIZATIONAL MODEL

One of the most distinguished contemporary management authors recognized for his expertise, innovation and dynamism is Henry Mintzberg of Canada's McGill University. According to Mintzberg (1993), most organizations can be divided into five basic components: operating core; strategic apex; middle line; technostructure; and support staff. At the bottom of the organization is the operating core; the people who do the basic work of producing the products or delivering the services. The operating core could include purchasing agents, machine operators, assemblers, sales persons, and shippers. The second component, the strategic apex, ensures the organization executes its mission. They are responsible to the owners, government agencies, unions, communities, etc. and include the board of directors and chief executive officer. The strategic apex is joined with the operating core by a chain of middle line managers who transmit authority from the top to the bottom. The middle line managers include the vice presidents, plant managers and sales managers (Mintzberg, 1993).

The fourth component of Mintzberg's organizational structure is the technostructure. These individuals determine the organization's technology and procedures. These personnel effect coordination through standardization and include strategic planners, controller, personnel trainers, operations researchers, production schedulers, systems analysts and designers. The final component in Mintzberg's organizational hierarchy is support staff. These are the administrative units that provide services to the organization and are made up of workers in the mailroom, cafeteria, legal council, public relations, etc. Figure 4 illustrates Mintzberg's five basic components.

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Figure 4. Mintzberg's Five Basic Subunits

Strategic
Apex

Technostructure

Middle
Line

Support Staff

Operating Core
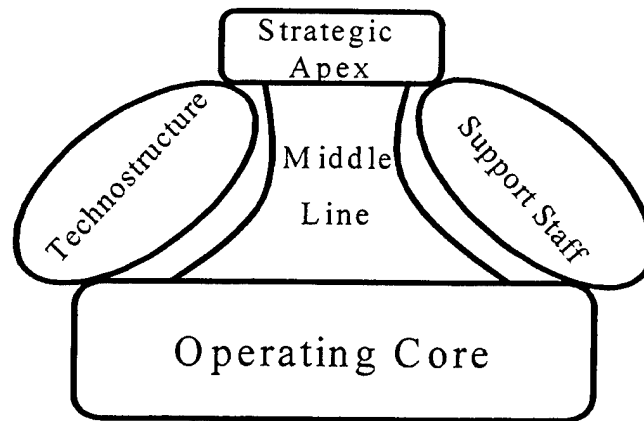
Mintzberg further contends that the characteristics of organizations fall into one of five natural configurations and that organizations differ from each other based on how the five components (operating core, strategic apex, middle line, technostructure and support staff) interact with one another, and by which component is dominant in the organization. The five natural configurations according to Mintzberg are the simple structure, machine bureaucracy, professional bureaucracy, divisionalized form, and adhocracy. The simple structure is based on direct supervision in which the strategic apex is the dominant component. The machine bureaucracy is based on standardized work processes in which technostructure is the dominant component. The professional bureaucracy, on the other hand, is based on standardized skills in which the operating

core is the dominant component. In the divisionalized form, managers in the strategic apex directly supervise the work of subordinates. Lastly, the adhocracy is based on teams of professionals from the operating core, support staff, and technostructure relying on informal adjustment to coordinate their efforts (Mintzberg, 1993).

For the purpose of this thesis and its relevance to the organizational structure of healthcare facilities, only the professional bureaucracy will be discussed further. As previously stated, the professional bureaucracy's dominant and largest component consists of the operating core, which in a health care facility is made up primarily of professionals (doctors, nurses, technicians, dentists, etc.). These professionals rely on the skills learned from years of schooling to accomplish their work. Members of the operating core are self-organized learners and attend conferences, peer group meetings and re-train to keep up with their field or become more specialized. Professional bureaucracies predominantly hire highly trained specialists for the operating core, and then give them considerable control over their work. With this control, professionals work fairly independently of their colleagues, but closely with the clients they serve (Mintzberg, 1993).

Unlike the machine bureaucracy, which generates and enforces its own standards, the operating core in a professional bureaucracy is controlled by external laws and self-governing professional associations, which standardize the skills and knowledge required of their members. Professionals in the operating core oppose the intrusion of the technostructure in their work environment for fear of losing control, autonomy, and moving toward a machine bureaucratic form. The professional bureaucracy is an inflexible structure, resistant to externally imposed change. Changes in the professional

bureaucracy do not occur as a result of the strategic apex making major reforms, but from changing who enters the profession, what they learn in professional schools, and how willing the professionals are to maintain their skills later on in their careers (Mintzberg, 1993). Figure 5 illustrates Mintzberg's Professional Bureaucracy.

Figure 5. Mintzberg's Professional Bureaucracy

Strategic Apex

Technostructure

Middle Line

Support Staff

Operating Core

From: Mintzberg, H., *Structure in Five, Public Policy*, 1993.
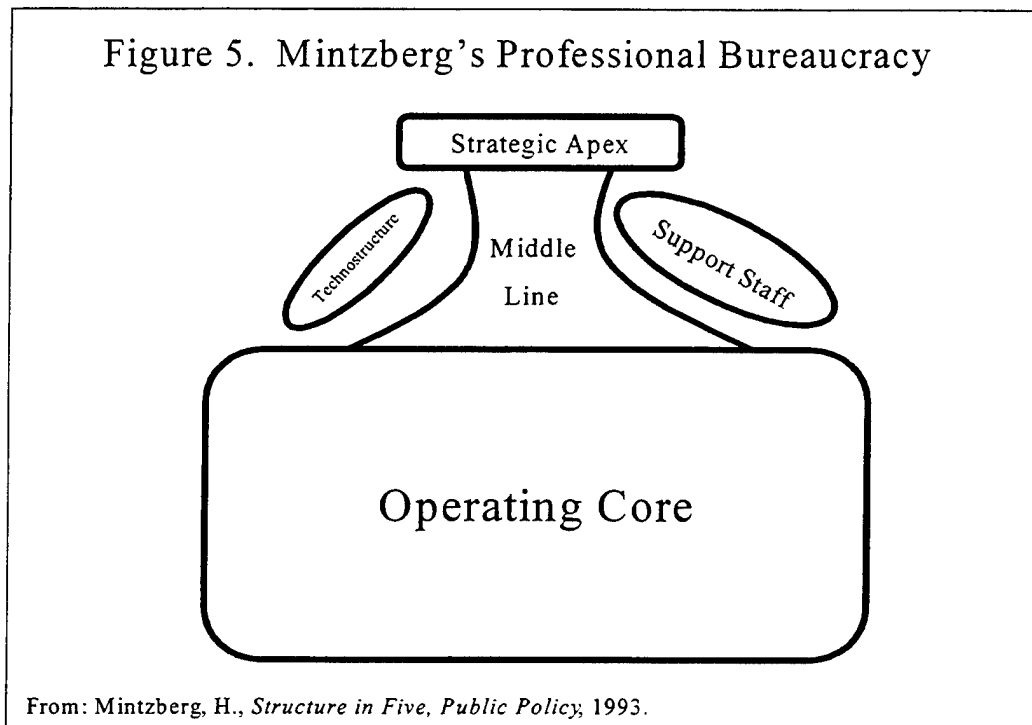
E.   SYSTEMS MODEL

Systems models have been well recognized since the 1950s and have been used to evaluate public policy, clarify specific characteristics of organizations, and explain the interrelationships between all of the elements that influence an organization (Dye, 1995; Kahn, 1977; Lawrence, 1990; Nadler & Tushman, 1992; and Roberts, 2000). Systems

models differ in scope, but many of the underlying principles remain the same. Most organizations are dependent on the external environment for resources, people, information, and feedback. Systems models invariably have three things in common (inputs, throughputs, results). To the extent that the various factors are aligned determines how well a complex organization performs (Nadler & Tushman, 1993). Systems theory also recognizes the importance of adapting to external forces, i.e., increasing effectiveness. Organizational leaders interpret the external environment and set direction, typically through goals, mission, vision, and policies. Managers intervene by changing structure, people, tasks and technology. Results emerge in terms of culture, outputs and outcomes. The point is to realize that the overall system is dynamic and non-linear. Cause and effect are often not close together in time and space. It is important for an organization to design and implement ways to adjust to environmental changes by realizing that all the components are interdependent.

The Systems Model, illustrated in Figure 6, further developed by Roberts (2000), uses a combination of several different model attributes and provides a more inclusive tool for organization analysis on a broader scale. This thesis will use Roberts' Systems Model framework for further analysis in Chapter V.

Figure 6. Organizational Systems Model

Inputs → Throughput → Results

Design Factors

ENVIRONMENT/CONTEXT
(external to system)

➢ Political?
➢ Economic?
➢ Social?
➢ Technological?

KEY SUCCESS FACTORS

What does it take for the system to be successful?

SYSTEM DIRECTION

➢ Mandate?
➢ Values?
➢ Mission?

➢ Strategic Issues?
➢ Vision?
➢ Goals?

➢ Strategies?

TASKS/JOBS

➢ What are the basic tasks? How formalized?
➢ What specification is required? How varied?
➢ What differentiation is required?

TECHNOLOGY

➢ How can the work flow be described?
➢ What are the activities in the work flow?
➢ What are the key inter-dependencies among the work units or activities in the work flow?
➢ What is the condition of the physical facilities and equipment?

STRUCTURE

➢ How to describe the structure?
➢ What are the basic groupings of activities and people? How are activities/tasks combined? Departmentalized?
➢ How are the groupings integrated? What integrating devices are used?

- Hierarchy?
- Task Forces?
- Integrating Roles?
- Integrating Departments?
- Matrix?
- Networks?

PEOPLE

➢➢ Who are the people? Motives, expectations, mindsets?
➢➢ What are their knowledge, skills and abilities?

PROCESS/SUBSYSTEMS

➢ Financial Management, Measurement & Controls?

- How are people held accountable for resources? Describe: budgeting, control, performance measurement, performance appraisal processes.
- Do these mechanisms of accountability produce the desired pattern of behavior?

➢ Human Resource Management

- How do we recruit, select, retain, rotate, promote, Terminate, retire our people? Do we have the kind of People we need?

- How do we train and develop people and are our current efforts adequate? Describe: OJT, formal training programs, team building or other organizational development activities, career development.

- What is formally rewarded (both positive and negative rewards)? What is the basic compensation package: bonus & commissions, opportunities for advancement, recognition & praise? Are rewards tied to performance assessment?

➢ Communication Information Planning and Decision Making

- How do we communicate?
- How do we gather, process, distribute and evaluate Information?
- How do we plan?
- How do we make decisions?

➢ Acquisition & Contracting: How do we manage the acquisition process?

CULTURE

➢ Prevalent norms and values in the system as they are expressed in behavior?
➢ How is conflict managed?
➢ What are the informal patterns of interaction?
➢ Are there Sub-cultures?
➢ Does culture(s) impede or facilitate integration of effort?
➢ Does the culture(s) fit the larger environment?

OUTPUTS

➢ What does the system offer/ produce in terms of goods and/or services?
➢ How are outputs measured? What are indicators of performance?

OUTCOMES

➢ What are the implications/ consequences of outputs for stakeholders?
➢ How are outputs viewed in terms of the environment?
➢ How are outcomes measured?

1.   Environment/Context

The first element in the Systems Model is the environment/context of the organization. In this element, the organization's external environment, or the context within which the organization operates, is analyzed. The organizational environment includes all elements, people, other organizations, economic factors, objects and events that lie outside the boundaries of the organization. The organizational environment includes both the general and the task environment. The general environment includes the broad set of dimensions and factors within which the organization operates, including the political-legal, economic, socio-cultural, and technological factors. The task environment includes specific organizations, groups, and individuals that influence the organization. People in the task environment include customers, donors, regulators, inspectors and shareholders. Organizations in the task environment include competitors, legislatures, and regulatory agencies.

2.   Key Success Factors

Key success factors are those things that the organization must do well in order to succeed, i.e. a hospital must employ qualified and competent doctors and nurses. Factors could include performance measures that assess accomplishment of critical service (cycle times for various illnesses). Key success factors should be reflected in strategic and business plan objectives and goals. For each success factor there should be an associated key indicator that provides a measure of accomplishment.

3.   System Direction/Strategy Formulation

The next element in organization design is how the organization sets direction. This element could include the organization's mission, objectives, short and long-term

goals, strategies and policies. Without these important direction-setting components, an organization is more subject to reacting to its environment. Direction and strategy formulation can be based on a number of factors which are briefly discussed below.

a. Mandates

Mandates consist of organizational imposed rules and policies, as well as federal, state and local laws, codes and regulations. Mandates are regarded as constraints to the organization and must be considered as such during the direction setting/strategy formulation phase. Organizations must be aware of all mandates affecting them, or be prepared to face significant penalties and ramifications. There are both formal and informal mandates. Formal mandates include public laws, fire codes, and Food and Drug Administration regulations. Informal mandates include public perception, ethics and moral beliefs (Bryson, 1995).

b. Values

Values and dominant beliefs affect how events and communications are interpreted and promulgated within an organization. Values affect motivation and culture. Shared values and beliefs can hold organizations together, and conflicting values cause disharmony and dysfunction.

c. Mission

The mission should reflect and capture why the organization exists and what it is supposed to accomplish. It should include the overall vision and purpose of the organization for all the employees. The mission describes how the organization goes about creating and delivering value to its customers and stakeholders. The mission also describes the current and/or near term activities, technologies, and competences that the

organization is engaged in. The mission might identify customers, critical processes, intended results and expected level of performance.

d. Strategic Issues

Strategic issues are the fundamental policy questions or challenges affecting an organization's mandates, mission and values, and product or service level mix (Bryson, 1995). Issues can arise from economic, societal, or political factors. The environment often presents a new set of issues based on factors outside an organization's control, i.e., managing a diverse workforce. Trends and developments should be assessed to determine if they are important to the organization's future. In summary, an organization can set its direction based on real-time strategic issues.

e. Vision

Peter Senge (1994) believes that every organization has a destiny, or a deep purpose that expresses the organization's reason for existence. A shared vision helps people set goals to advance the organization. It is also a vital source for employee motivation and empowerment. Without understanding the organization's purpose and future working environment, employees are limited to only working in the present.

f. Goals

Goals represent a classical or traditional way to set direction, i.e., improve patient satisfaction by ten percent. Goals should be measurable, attainable, and linked to strategy. The level of specificity of goals depends on the nature and needs of the organization. To ensure that members of an organization have a clear understanding of its goals, considerable detail should be made available to them regarding individual goals.

g. Strategies

Johns (1992) defines strategy as "the process by which top executives seek to cope with the constraints and opportunities posed by the organization's environment." Strategies are the plans to attain outcomes consistent with the organization's mission and goals. Strategy can be looked at from three levels: (1) strategy formulation, or developing the strategy, (2) strategy implementation, or putting the strategy into action, and (3) strategic control, or modifying either the strategy or its implementation to ensure that the desired outcomes are attained.

4. Design Factors

Organizational design factors include tasks, technology, structure, people and processes/subsystems as defined below:

a. Tasks/Jobs

A task is a unit of work or a set of activities needed to produce some result. A job is a collection of tasks and responsibilities that an employee is responsible to conduct.

b. Technology

Technology refers to the workflow of the organization, the mutual support among the work units or activities in the work flow, and the physical facilities and equipment used to accomplish the work. The process by which inputs or information sources are transformed into outputs or services reflects an organization's technology. Different parts of the organization use different technologies depending on their mission, functions, and capabilities.

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c.   *Structure*

Structure refers to the basic grouping of activities and people, how these groupings fit the workflow, and how they are integrated. It includes the manner in which organizations divide labor into specific tasks and achieve coordination among the tasks.

d.   *People*

Organizations are of course composed of people. This design variable refers to the hiring, selecting, promoting and disciplining of personnel in an organizational. Labor costs typically consume over 60 percent of an organization's resources. Organizational performance is tied directly to the capability of its people.

e.   *Processes/Subsystems*

Process is best defined as a function within an organization that enables the organization to successfully deliver its products and services. In the context of this model, processes/subsystems includes the functional areas of an organization such as financial management, human resource management, communications, information management/technology, planning, decision-making, and acquisition and contracting.

5.   Culture

Schein (1992) defines culture as "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid, and therefore, be taught to new members as the correct way to perceive, think, and feel in relation to those problems." Patterns create norms that define acceptable behavior from the top down. Culture can be viewed as an emergent property.

6. Outputs

Outputs refer to goods and services produced. Outputs can serve as a measure of success for an organization in terms of accomplishment of goals and objectives, efficient and effective use of resources, and successful adaptation to a changing environment.

7. Outcomes

Outcomes refer to the implications/consequences of outputs for the stakeholders, and how these outputs are viewed in terms of the environment. Outcomes provide a focus and rationale for the specification and production of outputs. By using an effective mix of outputs, organizations can decide how to achieve their required outcomes. There is not a one-to-one relationship between outcomes and outputs i.e. several outputs may contribute to one outcome, and one output may contribute to the achievement of more than one outcome.

F. ELITE THEORY MODEL

The Elite model of decision-making assumes that the values and preferences of the few who govern a society or an organization dominate policy and strategy determination. Elite theory assumes that society in general is uninterested when it comes to policy making, and as such, the governing few make policy decisions for the uniformed or apathetic many. Elite theory recognizes that lower and middle class members can move into positions of the governing apex, however, this movement should be completed slowly to ensure stability in the governing body (Dye, 1995).

In the Elite Theory model, public policy changes usually take place incrementally and are a result of the governing few modifying their own values and preferences. In

general, the governing few can be categorized as conservative, and as such, prefer incremental policy changes. Seldom do the elites replace public policies. However, when the political system is threatened, elites may be forced to make broad policy changes in an effort to preserve their stake in the system (Dye, 1995). Figure 7 illustrates the Elite Theory Model.

Figure 7. Elite Model

Elite

Officials and Administrators

Mass

From: Dye, Thomas R., *Understanding Public Policy*, 1995.
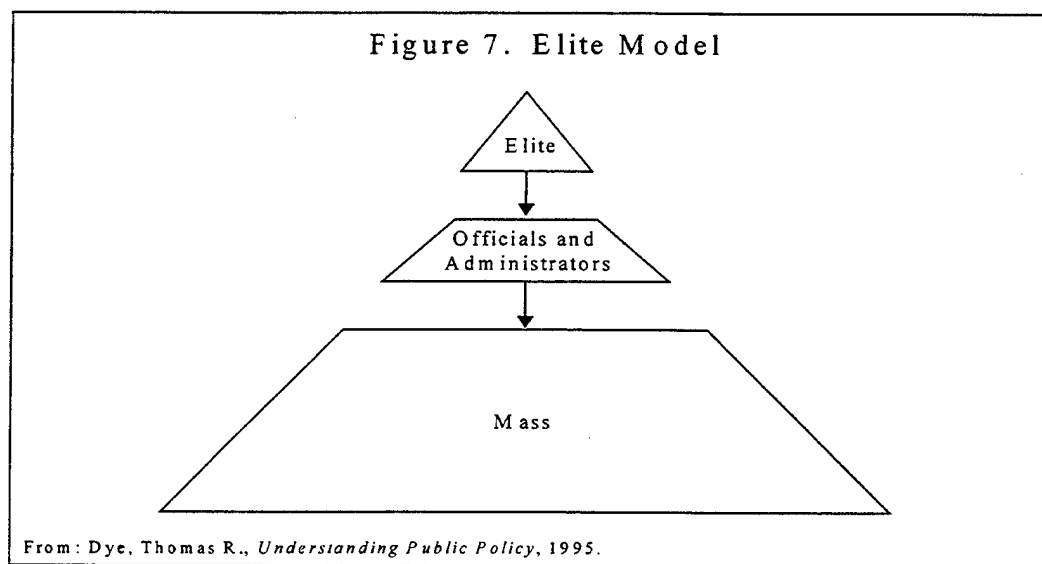
G.   INCREMENTAL MODEL

The Incremental Model of policy making originated with political scientist Charles E. Lindblom (1979) who described various actors with conflicting values involved in policy-making and implementation. Because there are so many different actors involved, there is often disagreement on which policy issues to address, or how goals should be pursued. As a result, decision-making produces policies that are similar

to previous ones i.e., real changes occur incrementally at the margins. Lindblom (1995) noted that some problems are so complex, that even the smartest, most persistent leaders are unable to implement comprehensive change. As a result, decision-makers typically "muddle through" complex problems with small changes in the status quo. Decision-makers often derive solutions that are "satisficing," i.e., good enough, then move on to the next problem (Lindblom, 1995). Figure 8 shows the typical Incremental Model in terms of policymaking and program changes.

Another aspect of incremental policy making is that many organizations and policymakers lack the time, information, and resources to explore all of the costs and benefits of implementing various alternatives. Due to the uncertainty of implementing new policies, policymakers continue current policies and tweak them incrementally. Organizations typically have investments in infrastructure, people and operations, and as such, policymakers can be overly cautious in terms of not upsetting existing structures and power centers. Incremental policy-making reduces conflict and produces more rapid policy decisions. Small changes in current policies and programs result in less disagreement among participating stakeholders, ultimately leading to quicker policy decisions (Dye, 1995).

Figure 8. Incremental Model

From: Dye, Thomas R., *Understanding Public Policy*, 1995.
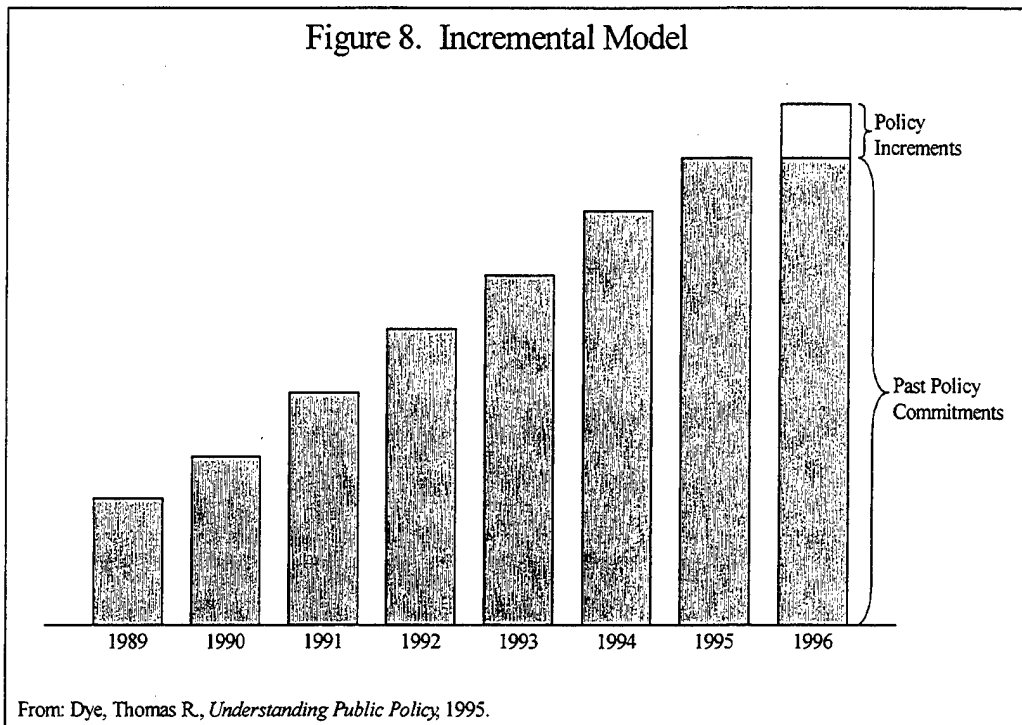
H.   BUREAUCRATIC-POLITICS MODEL

The Bureaucratic-Politics model reveals that policy decisions reflect compromise, conflict, and confusion resulting from the interplay of policymakers with diverse interests and unequal influence. This model examines how organizational interests influence the policy process and how decision makers bargain and compromise in the policy process (Lindblom, 1979). Similar to the incremental approach to decision-making, the Bureaucratic-Politics model assumes that the involvement of many diverse actors in a policy decision can lead to conflicting goals, i.e., actors often bargain and negotiate to reach decisions that are potentially rational. Decision-makers can shift from old goals to new ones depending on an evolving political agenda (Quade, 1989). Compromise,

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appeasement and a willingness to accept modest returns allow policy-makers to build allies and gain political advantage.

In the Bureaucratic-Politics model there is not one actor acting alone, but multiple actors often pursuing different agendas. Lobbyists are often involved in shaping policy decisions. Policy changes may be carried out within existing laws and regulations, or changes may be required (Quade, 1989).

IV. COMMAND SCREENING PROCESS

A. OVERVIEW

This chapter describes the Navy Medical Department's command screening process. Eight other Navy line and staff communities' command screening and selection processes are also briefly described and compared, including the civilian healthcare selection process for Chief Executive Officers (CEOs) and Chief Operating Officers (COOs). The Navy Medical Department command screening process is described in three phases beginning with Naval Personnel Command (NAVPERSCOM) staff preparations for the formal board, to selection of individuals for MTF/DTF CO and XO positions. Information for this chapter was obtained primarily through interviews conducted at NAVPERSCOM with assignment officers (detailers) in the medical, aviation, Civil Engineering Corps (CEC), fleet support, Judge Advocate General (JAG) Corps, meteorology/oceanography (METOC), submarine warfare, Supply Corps (SC), and surface warfare communities. Information regarding the civilian healthcare sector was obtained from healthcare executive journals, and interviews with one CEO and one senior vice president, or COO equivalent.

Before describing the Medical Department command screening process, the roles and responsibilities of COs and XOs are explained. OPNAVINST 3120.32C, The Standard Organization and Regulations Manual (SORM), defines the CO as the "person charged with the absolute responsibility for the safety, well-being, and efficiency of his or her command. The duties and responsibilities of the CO are established by U. S. Navy Regulations, general orders, customs, and traditions." The SORM defines the XO as the

"direct representative of the CO. The XO conforms to and carries out the policies and orders of the CO and shall keep him/her informed of all significant matters pertaining to the command...the XO is primarily responsible under the CO for the organization, performance of duty, and good order and discipline of the entire command."

Prior to 1989, the Navy Medical Department did not have a formal command screening process, did not identify a clear career path to command, and did not provide any formal criteria for selecting the "best qualified" officers for CO/XO positions. The first formal Medical Department command screening board was held in 1989 and mirrored command screening boards of the other line and staff communities. Career pathways to command were developed and published in the 1991 Navy Medical Department Officer Career Guide for each of the four corps (Appendices D through G), and screening elements were established to select the "best qualified" individuals into a pool of potential candidates for command assignments. These screening elements included: grade, subspecialty code(s), activity codes, Naval Officer Billet Description Codes (NOBCs), and training (Medical Department Officer Career Guide, 1991).

The goal of the Medical Department command screening process is to select the "best qualified" officers. Written Navy policy regarding application of the "best qualified" standard relates primarily to operational type commands. The Surgeon General (SG) defines "best qualified" as "demonstrated potential to succeed in a position of special trust; high personal standards; exceptional leadership skills; solid understanding of MTF/DTF and operational respective roles; broad based experience. Must be willing, able and available." Traits of the "best qualified" officer include: "strong character; hard working; energetic; calculated risk taker; can act in the absence of

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absolute information; does not hide behind the rules, has a fire in their belly; coach, team builder; celebrates other's success; knows how to use TQL/TQM tools; subscribes to best practices (clinical/business); innovator/fosters innovation." The "best qualified" officer also "understands and supports organizational goals; is highly motivated to accomplish them by leading and inspiring staff. Understands, appreciates, and responsive to internal/external dynamics (MTF/DTF/RLC/Operational-Fleet requirements) that are inherent in executive medicine positions" (Medical Assignments/Placement Branch slide presentation, Fall 2000).

The Medical Department command screening board proceedings have remained fairly constant since its inception. All formal command screening boards are designated as administrative boards by CNP, and as such, are conducted using the same mandates as promotion selection boards. Title 10, United States Code, Section 611 covers the convening of selection boards and SECNAVINST 1401.3 covers selection board membership. Changes to administrative board procedures require SECNAV approval. The criteria used to select the "best qualified" officers in the Medical Department command screening process have changed significantly since its inception due to several environmental changes. Military downsizing, shifting control of Navy Medicine's financial and personnel resources from line Navy to the Assistant Secretary of Defense for Health Affairs (ASD(HA)), and queries into the quality of health services being delivered in the Military Health System (MHS) in the early 1990s sparked strong Congressional interest. The DoD Appropriations Act of 1992 specifically stated that, "None of the funds appropriated in this Act may be used to fill the commanders position at any MTF with a health care professional unless the prospective candidate can

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demonstrate professional administrative skills" (Memorandum for Secretaries of the Military Departments, 18 December 1991). Similar verbiage was included in the fiscal year (FY) 96 and FY01 DoD Appropriations Acts (electronic mail from CDR J. Souza, 24 January 2001).

In response to the 1992 DoD Appropriations Act, a tri-service working group was established to identify the basic skills/competencies needed before a potential MTF CO/XO could assume command. Using hospital administration standards from the civilian healthcare sector as a guide, the working group produced a list of 40 skills, or competencies required of potential MTF COs/XOs. The competencies were divided into eight main areas: military medical readiness, general management, health law and policy, health resources allocation and management, medical ethics, individual and organizational behavior, clinical understanding, and performance measurement. Appendix H provides a list of the 40 competencies that have been added to the Navy Medical Department's command screening board selection criteria.

Another aspect directly impacting the Medical Department command screening process is a defined career path to command. The Medical Corps, Dental Corps, Medical Service Corps, and Nurse Corps each use their own career path matrices (Appendices D through G). The SG recently tasked each of the Corps Chief's/Director's offices to develop one universal executive medicine career path matrix for all four corps (Interview with CAPT A. Barrow, 13 December 2000). Appendix I is a proposed draft of the executive medicine matrix, which provides a list of executive medicine positions available to Medical Department officers as well as possible pathways to acquire these

positions. The pathways are meant to provide guidance to Medical Department officers at different stages in their careers.

B.   NAVY MEDICAL DEPARTMENT COMMAND SCREENING PROCESS

The Medical Department command screening board is an administrative board held each September and is listed on NAVPERSCOM's official board schedule. The command screening and selection process is conducted in three phases: 1) CO/XO screening board establishes eligible pool, 2) potential candidates identified/nominated for command positions, and 3) Council of Corps Chiefs reviews and approves nominations. Prior to a discussion of the three phases, a brief description of the key stakeholders is provided.

The Navy SG serves as a special assistant/resource sponsor on the CNO/OPNAV staff and the Chief, Bureau of Medicine and Surgery (BUMED). The SG serves as the president of the Medical Department command screening board, and the Chairman of the Council of Corps Chiefs. The Manual of the Medical Department (MANMED, 1996) describes the Chief, BUMED's responsibilities as "ensures personnel and material readiness of shore activities as assigned by the CNO for command; to develop health care policy for all shore-based treatment facilities and operating forces of the Navy and Marine Corps; to provide primary and technical support in the direct health care delivery system of shore-based treatment facilities and operating forces of the Navy and Marine Corps; and to manage the use of the TRICARE program, and other indirect health care delivery systems." The Council of Corps Chiefs works together to evaluate issues that impact all Navy Medical Department communities. The council is comprised of the Chief, BUMED, Chiefs/Directors of the Medical Corps, Dental Corps, Medical Service

Corps, Nurse Corps, Hospital Corps, and a senior civilian representative appointed by Chief, BUMED (Manual of the Medical Department, 1996).

1. Phase One: CO/XO Screening Board Establishes Eligible Pool

Approximately 120 days prior to the board convening date, several key stakeholders begin the process. The offices of the Medical Corps (MED-00MC), Medical Service Corps (MED-00MSC), and Nurse Corps (MED-00NC) in Washington, DC, distribute over 700 command screening surveys (Appendix J) to Captains (CAPTs) and individuals selected for CAPT (CAPT(select)) in their communities who have not previously screened for CO and/or XO. In addition, the Head, Dental Corps assignments (PERS-4415G) in Millington, TN distributes over 100 command screening surveys to the eligible DC CAPTs and DC CAPT(select) in his/her community.

The surveys are returned to the sending Corps Chiefs/Head DC assignments offices via fax, electronic mail or by U. S. Postal Service. Return rates for the command screening surveys range from 65 percent for the Medical Corps to 84 percent for the Medical Service Corps. Current Navy Medicine policy states that Medical Department officers may voluntarily withdraw their name from the list of eligibles with no negative impact to their career. The Corps Chief's office/Head DC assignments reviews and compiles the results. In most cases, the Corps Chief will be briefed by a member of his/her staff on the quantity and quality of responses. Not every eligible CAPT/CAPT(select) responds to the survey. No response is perceived as "does not wish to be screened for CO/XO." Some eligible CAPTs may be contacted personally by the Corps Chief's office/Head DC assignments regarding their survey responses, or failure to respond. Once processed, MED-00MSC and MED-00NC mail the completed surveys to

the head of their respective detailing/assignments branch at NAVPERSCOM. MED-00MC sends copies of the surveys to the Medical Department command screening board senior recorder and maintains the original surveys for the Corps Chief to hand carry with him/her to the official board proceedings. The Head, MC assignments (PERS-4415M) is the only assignment officer not involved in their community's survey process, a decision made by the current Chief of the Medical Corps (MED-00MC).

The MSC (PERS-4415I/4415J), DC, and NC (PERS-4415K) assignment officers process the returned surveys in a similar manner. Members who wish to be screened are separated from those who do not wish to be screened. The assignment officers review personnel records of the members who wish to be screened in the Officer Assignment Information System (OAIS) and Electronic Military Personnel Record Information System (EMPRIS) to ensure the officer is not missing any information (fitness reports, photographs, etc.) before their record appears before the board. The assignment officers may also call the member to obtain missing documents, and/or to clarify individual survey responses. Once the assignment officers have completed their review, the surveys are forwarded to the command screening board's senior recorder.

At the same time the survey process is being initiated, the Special Assistant for Selection Board Matters (PERS-451F) prepares and forwards a draft board precept to the command screening board's senior recorder. Since the inception of the formal board, the person serving as the Head, Medical Placements Branch (PERS-4415B) has always served as the Medical Department command screening board's senior recorder. The board's senior recorder reviews the command selection board's proposed precept and forwards a draft to the Navy SG for review and approval. Once approved by the SG, the

board's senior recorder returns the precept to PERS-451F for final processing and to obtain the Deputy Chief of Naval Personnel's (DCNP) signature.

The command screening board's senior recorder receives all of the completed surveys from each of the four Corps. The board's senior recorder prepares a spreadsheet in Excel and downloads all Medical Department CAPTs and CAPT(select) information from OAIS into one Excel file. Included in the data file is one data field that tracks if a member is currently CO/XO screened, if the member has submitted their retirement papers, if the member has/will reach the statutory retirement age, or if the member will reach over 30 years of commissioned service during the next fiscal year. Any member who falls into one of the last three categories is not eligible for command screening. The board's senior recorder enters each survey response into one of three categories in the Excel file: positive reply, negative reply, or did not reply. Once this Excel spreadsheet is finalized, it is used as the board master list and forwarded back to PERS-451 (Board Matters) to have the records pulled for the formal board proceedings. One week prior to the board convening date, the other board recorders arrive in Millington, TN to begin preparing records for the board member's review. The board senior recorder maintains the returned command screening surveys in the boardroom in the event a board member requests to examine a specific individual's survey response.

Each year, the Navy SG serves as the president of the Medical Department command screening board and the Corps Chiefs/Directors serve as board members representing their respective Corps. Potentially, the SG and Corps Chiefs could serve on three consecutive Medical Department command screening boards. Repeat board membership is not permitted under Title 10 United States Code, or SECNAVINST

1401.3. The Navy SG requested and received SECNAV approval to waive the restriction of repeat board membership. Written documentation of this waiver was not available to the researchers. This is the only NAVPERSCOM board with the same board membership each year.

The board members arrive one to two days prior to the board convening date. As with statutory boards, board members cannot converse with the assignment officers prior to, or during the board proceedings. The board formally convenes on a Wednesday in the formal boardroom spaces (Building 200, Wood Hall) at NAVPERSCOM. The board's senior recorder swears-in all board members. The president of the board (SG) presents his goals and objectives of the board proceedings, and reviews the board precept with the board members. The board members use EMPRIS to electronically review the records of their respective community (MC, DC, MSC, NC) only. The SG reviews records of MC officers since he is usually of that Corps and the pool of eligible MC candidates is much larger. Board members initially review service records of the members who are already screened to determine whether any negative conduct, or any other reasons why the screened member should be removed from the screened pool. The members then review the records of the individual's who requested screening. Some members who did not respond to the survey are also screened based on the SG's and/or Corps Chief's preference.

Once all records have been reviewed, the proceedings move to the tank room. Board members identify individuals who either voluntarily request to be removed from the screening pool, have demonstrated adverse performance since the last screening board, or have some other situation that may make them ineligible to continue to serve in

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the command screened pool. The Officer Transfer Manual (OTM) refers to this process as "descreening," whereas the Medical Department refers to it as "administrative removal." The board votes on each individual identified in the "administrative removal" category. Next, board members brief the Officer Summary Records/Performance Summary Records (OSRs/PSRs) of the eligible members in their specific community in the same manner as in statutory promotion board proceedings. All board members vote using the same voting system used during promotion selection board proceedings.

The criteria used to select the "best qualified" officers include: performance as documented in the member's fitness reports (FITREPs), history of assignments, service reputation, educational attainment, and experience. FITREPs are reviewed for comments regarding the individual's potential for command, and depending on the Corps, 4.0/5.0 grades in the leadership block are required. Officers' assignment histories are reviewed for follow-on tours with increased scope and responsibility. Career paths vary depending on the Corps affiliation of the officers. MC officers can serve as department heads (DHs) at MTFs or operational units, Directors for Clinical Services (DCS), Medical Services (DMS), Surgical Services (DSS), and Ancillary Services (DAS), and medical directors. DC officers serve as division officers, DHs at shore based or operational units, officers-in-charge (OICs) of branch dental clinics, and dental annexes. MSC officers can serve as division officers, DHs at ashore and with operational units, OICs of branch medical clinics, and Directors for Administration (DFAs). NC officers can serve as division officers, DHs, senior nurses, OICs of branch medical clinics, and Directors for Nursing (DNS).

The number of active duty CAPTs in each of the four Corps ranges from 167 in the Nurse Corps to 569 in the Medical Corps. Due to the size and worldwide distribution of officers, Corps Chiefs/Directors will not know every CAPT in their respective Corps. As with promotion selection boards, service reputation plays an important role when one or more of the command screening board members is/are aware of an individual's performance. Otherwise, board members can only interpret what is recorded in the service record. Educational attainment acts primarily as a tiebreaker in command screening board selection. Most officers in the Navy Medical Department have a master's degree or above before they attain the rank of CAPT. Some MC, DC and NC officers will complete a master's degree in business administration, public health, or healthcare management on their own time, which is noted by board members. The 40 competencies are included in the experience factor. This is a combination of the various assignments, formal and informal courses, and affiliation with professional organizations that include, as part of membership or advancement, credentialing and continuing education.

In the past, only potential COs/XOs of the MTFs and DTFs were selected during this board. The selection of COs/XOs for medical research, training, drug screening labs, and other types of commands were done informally and not part of the formal command screening board. Beginning in September 2000, however, candidates are assigned into one of three command-screened categories: 1) Command MTF, 2) Command DTF, or 3) Command Other (medical training commands, medical research commands, drug screening labs, etc.). After all "eligibles" have been voted on, the board reconvenes to the boardroom spaces and selects several cut-off scores. All members scoring above an

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agreed upon score are considered screened, members falling below an agreed upon score are not considered screened, all members falling in between these two scores remain in the crunch. The briefing and voting process continues until all members fall into the screened or not screened category. The command screening board precept identifies the quota, or number of officers that may be selected for CO or XO screening at the board.

Once all members have either been selected or not selected, the board votes on the overall list and the board's senior recorder documents the vote to conclude the formal board proceedings. Once the board is completed, the SG and Corps Chiefs can converse with the Medical Department assignment officers. A personal visit, or board "call-out" by the board president to the DCNP and/or Chief of Naval Personnel (CNP) is optional on administrative boards. As with other administrative boards, the results can be released immediately after the board concludes. It is the SG's policy to hold the official sele message for 72 hours after the board concludes to allow time for the Corps Chief, assignment officer, or the newly selected individual's COs to contact and congratulate the officer. Once the board concludes, the senior recorder/Head, Medical Placements updates OAIS and adds the CO or XO screened code to the newly selected officers' records. Once screened, medical department officers can remain on the command-screened list until they either retire, are administratively removed, or request to have their name removed. The current list of screened CO/XO candidates is over 200.

Figure 9 is a flow chart describing the first phase of the Medical Department command screening process.

Figure 9. Navy Medical Department
Command Screening/Selection Process

PHASE ONE FLOW SHEET

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┌─────────────────┐
│   Corps Chiefs  │ ─────────►  ┌──────────────────────────┐
│     survey      │             │   CO/XO Screening Board  │
└─────────────────┘             │   Establish Eligible Pool│
                                └──────────────────────────┘
                                              │
┌─────────────────────┐                       ▼
│ Subject to SG's     │             ┌──────────────────────────┐
│ approval,           │             │      Identify/Validate    │
│ SG's Council of     │ ═════════►  │     Projected CO, XO and  │
│ Corps Chiefs,       │             │  other Executive Slate    │
│ Validates all CO    │ ◄═════════  │  vacancies                │
│ CONUS tours over    │             │  for next assignment cycle│
│ two years           │             └──────────────────────────┘
│ (PERS-4415 project  │
│ CO PRD list)        │
└─────────────────────┘
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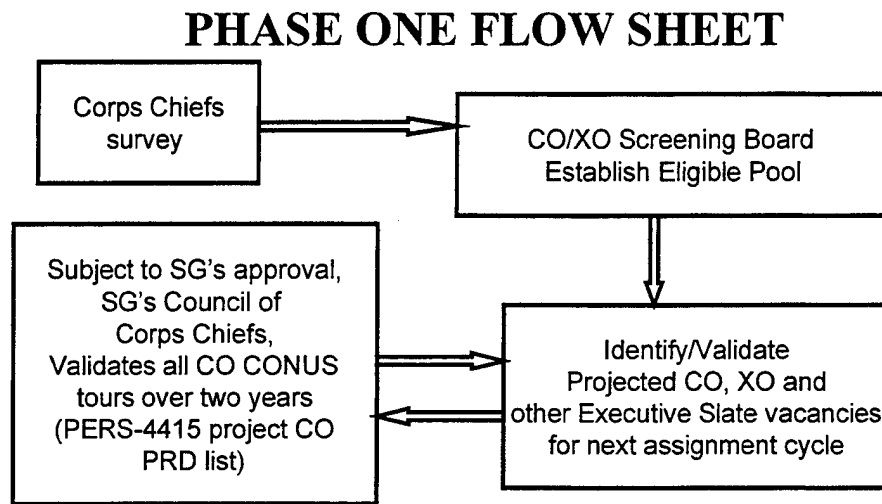
From: PERS-4415, September 2000

2.   Phase Two: Potential Candidates Identified/Nominated for Command Positions

After the command screening board has adjourned and the newly screened officers' personnel records have been updated with the command screened code, the assignment officers begin the process of identifying and validating upcoming CO/XO vacancies during the next assignment cycle. Once these vacancies have been confirmed, the senior assignment officer from each Corps (MC, DC, MSC, NC) identifies one to three potential candidates from their community for each vacancy. Current Navy Medicine policy states that only MC, MSC or NC officers can serve in MTF CO/XO billets and only DC officers can serve in DTF CO/XO billets. The identification process begins by reviewing personnel records of prospective candidates whose projected rotation dates (PRDs) fall within the billet vacancy timeframe. If there are no potential candidates

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available to rotate at the time of vacancy, the assignment officers will review records of individuals within a six to twelve month window of the projected vacancy date. DoD tour length policies must be taken into consideration, although they can be waived in certain circumstances. The assignment officers must also evaluate whether there are pending retirements, personal preferences or other circumstances that would limit an individual from being considered for the command billet.

In addition to the above issues, other organizational mandates and skillful job matching must be completed. One specific command assignment policy initiated by the current SG and approved by the Council of Corps Chiefs is that one CO or XO at each MTF must have been a credentialed provider at one point in their career. This policy specifically targets physicians, nurse practitioners, and clinicians in the Medical Service Corps community (clinical psychologists, physical therapists, etc.) who are credentialed providers. All DC officers are credentialed providers. Another policy recently implemented by the Council of Corps Chiefs concerns the length of CO tours. Prior to September 2000, CO tour lengths were three years. The new policy consists of two-year tour lengths with the third year at the invitation of the SG. XO tour lengths remain three years. Each assignment officer must also consider the CO/XO balance when generating a list of potential candidates. The strengths, weaknesses, personalities, and leadership style of the remaining CO/XO must be matched up with the right counterpart. Service reputation, the recommendation of the potential candidate's current/past COs and XOs, and the input of the Corps Chief/Director can influence the job matching process. During this process, assignment officers also discuss CO/XO vacancies with potential candidates

in their respective Corps. Current Navy Medicine policy states that Medical Department officers may turn down CO/XO assignments with no negative impact to their career.

The current list of eligible screened CAPTs is over 200 names long. Not every member on the command-screened list will receive a CO/XO nomination. PRDs, job matching issues, and the needs of the Navy may prevent a person from ever being nominated. Navy Medicine policy is to maintain a lengthy command screened list that provides senior leadership and assignment officers with the flexibility to fill command opportunities throughout the assignment cycle. After each assignment officer completes his/her review, they meet and discuss their candidates for each upcoming vacant command billet. Some Corps may be taken out of consideration for a vacant command billet due to Corps distribution issues. The Head, Medical Assignments/Placement Branch (PERS-4415) oversees these meetings. The assignment officers meet as often as necessary until a final CO/XO slate can be approved by a majority of the assignment officers. PERS-4415 confers with the SG, Deputy Surgeon General (DSG) and the respective Corps Chief while the initial slates are being developed. Upon completion, the command slate is forwarded to the Council of Corps Chiefs for review and approval.

3.   **Phase Three: Council of Corps Chiefs Reviews and Approves Nominations**

The third and final phase of the Medical Department command screening and selection process is the approval of the command slate by the Council of Corps Chiefs. Special meetings are called to discuss the recommended slate of nominees for MTF/DTF command positions. PERS-4415 is included in these meetings, either in person or via teleconference. The Council of Corps Chiefs can accomplish one of three actions:

approve the nominee(s), disapprove the nominee(s), or continue discussions on the entire

slate, or certain candidates on the slate. If the nominee is disapproved, PERS-4415 is

asked to submit an alternate name. After all of the nominees on the slate have been

approved, the DSG or his/her designee will notify each Responsible Line Commander

(RLC) of the individual's selection. The RLC serves as the reporting senior for

MTF/DTF COs in their geographic area. The approved slate is returned to PERS-4415,

which in turn, issues the orders for the prospective MTF/DTF COs and XOs. Figure 10

is a flow chart depicting p　㼀es two and three of the Navy Medical Department command

screening and selection process.

Figure 10. Navy Medical Department
Command Screening/Selection Process
PHASE TWO AND PHASE THREE FLOW SHEET

From: PERS-4415, September 2000
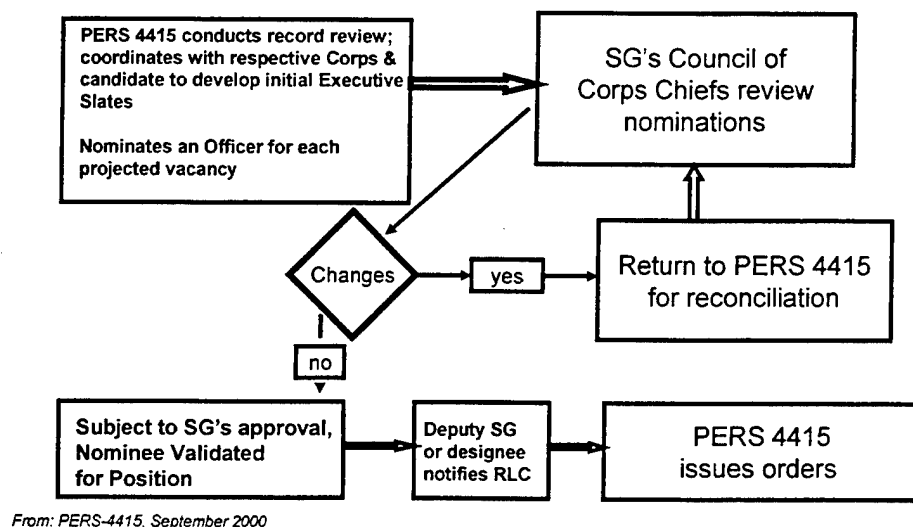
C. OTHER NAVY COMMUNITIES COMMAND SCREENING PROCESSES

To better understand the Navy Medical Department's command screening process, other Navy line and staff communities were also briefly examined. Eight communities were selected based on their size and the number of eligible command positions in relation to Navy Medicine and include: aviation, CEC, fleet support, JAG, METOC, submarine warfare, SC, and surface warfare communities. For the purpose of this thesis, screening to major command was not included in the comparison. Information for the comparison was obtained from interviews with assignment officers, Chapters 3 and 6 of the Officer Transfer Manual (OTM), and Policy Decision Memorandum 11-09-95 (Unrestricted Line and Fleet Support Officer Command Plan). Table 1 shows similarities and differences among the eight compared communities, which are discussed in greater detail below.

Table 1. Command Screening Process Community Comparison									
	Formal Board	Member Voluntary Withdraw w/ no negative Career Impact	Descreen Members	Rotate Board Membership	Guaranteed CO/XO job Once Screened	Minimum Rank for COs/XOs	Clear Career Path to Command	CO/XO Special Pay	Up or Out Policy
Medical	Yes	Yes	Yes	No	No	CAPT	Yes/No	No	No
Aviation	Yes	No	Yes	Yes	Yes	LCDR	Yes	Yes	Yes
CEC	No	Yes	N/A	N/A	N/A	LT	No	Op billets	No
Fleet Support	Yes	No	Yes	Yes	Yes	LCDR	Yes	Op billets	Yes
JAG Corps	No	Yes	N/A	N/A	N/A	CDR	No	No	No
Oceanography/ Meteorology	Yes	No	Yes	Yes	Yes	CDR	Yes	No	No
Submarine Warfare	Yes	No	Yes	Yes	Yes	LCDR	Yes	Yes	Yes
Supply Corps	No	Yes	N/A	N/A	N/A	CDR	No	No	Yes
Surface Warfare	Yes	No	Yes	Yes	Yes	LCDR	Yes	Yes	Yes

1. Aviation Community

The aviation community holds a formal administrative command screening board each year that is included on NAVPERSCOM's annual selection board schedule. Board membership rotates each year with an aviation Flag officer serving as the board president. Other board membership consists of aviation officers from the various operational communities, as well as one representative from the Commander, Naval Air Forces, Atlantic (COMNAVAIRLANT), Commander, Naval Air Forces Pacific (COMNAVAIRPAC), and Chief, Naval Air Training Command (CNATRA). Members should be at the rank of CAPT and/or CAPT selects with prior aviation command experience. The first look at command (13th year) occurs after the officer has been selected for Commander (CDR). Officers are eligible for three consecutive annual screens with the first two years primarily used to select for operational commands and the third year used to select for special mission commands. Tour lengths generally last 15-18 months and a screened XO in an aviation squadron fleets up to CO upon completion of a successful XO tour.

The aviation community has a distinct career path to command. A successful department head tour in one of the four larger departments (safety, administration, maintenance, and operations) is a career milestone to command. The typical career path to command for an aviator consists of:

- 0 - 3 years (training);
- 3 - 6 years (first sea tour);
- 6 - 8.5 years (first shore tour);
- 8.5 - 10.5 years (second sea tour...AW Staff, Carrier, Amphib);
- 10.5 - 11 years (training);
- 11 - 13.5 years (department head tour);
- 13.5 plus years (second shore tour...major staff, joint tour).

The board may descreen officers currently screened due to declining performance. The command screening board looks at an aviator's department head tour as the first discriminator (#1 of # on FITREP), and length of department head tour (#1 of # for how long). Second sea tour is a plus. Tiebreakers at the aviation command screening board include completion of Joint Professional Military Education (JPME), joint duty, major staff assignment, and completion of postgraduate education. Each community within the overall aviation community has a command plan, which includes the number of commands, the length of command tours, and the number of eligible aviators in each peer group. Every aviator screened for command will receive a CO/XO assignment. Every CO/XO select goes through Prospective CO/XO (PCO/PXO) course and either COMNAVAIRLANT's or COMNAVAIRPAC's one-week PCO/PXO course.

Aviation officers can submit a letter stating they do not want to be screened for command either before or after the board meets, or before or after they are selected for assignment. If an aviator turns down command or command screening, they most likely will not make CAPT. Aviators receive special command pay while serving as COs/XOs.

2.   Civil Engineering Corps (CEC)

CEC does not currently hold a formal command screening board. A formal board existed for two years, but was discontinued. The CEC community consists of approximately 1,250 officers with the following command opportunities:

- Lieutenant (LT): 2 XO billets;
- Lieutenant Commander (LCDR): 2 CO billets, 11 XO billets;
- CDRs: 11 CO billets, 15 XO billets;
- CAPTs: 21 CO billets, 8 XO billets.

The senior CEC assignment officer prepares the CDR and CAPT CO/XO slate and the Assistant Head/LCDR CEC assignment officer prepares the LT and LCDR CO/XO slate. The senior CEC assignment officer conducts quarterly briefing sessions with the five CEC Flag officers to discuss CO/XO assignments. There is not a defined career path to command. CEC officers may work in a variety of career fields including contracts, public works, construction battalions (Seabees), and staff officers. CO assignment lengths last two years; XO assignment lengths last for two to three years. XOs do not normally fleet up to CO.

Warfare qualification, experience, performance, service reputation, and recommendation for command in FITREPS are very important factors leading to command assignments. Since the CEC community is relatively small, the CEC Flag officers usually know the CDRs and CAPTs. CEC officers in operational CO/XO billets receive special command pay per Chapter 13 of the DoD Financial Management Regulations. Turning down a command assignment will not negatively impact a CEC officer's career. CEC officers selected for command assignment attend the PCO/PXO course, and as necessary, shore station command course. CEC officers selected for construction battalion command assignments must have served previously with the Seabees. The CO/XO slate for construction battalions is also reviewed by the Naval Facilities Command (NAVFAC), and current battalion COs to give them an opportunity to review their prospective XO candidate. The assignment officers look for good CO/XO personality matches. No metric for measuring successful command tours was found, but officers' FITREPs are occasionally reviewed during/after command assignments.

3. Fleet Support Community

Fleet support officers hold a variety of subspecialty codes including logistics, space/electronic warfare, shore installation management, financial management, transportation, education and training, operations analysis, and manpower. The fleet support community holds separate LCDR and CDR formal administrative command screening boards each year and both are included on NAVPERSCOM's annual selection board schedule. Board membership rotates each year with a Flag officer from the fleet support community serving as the board president. Three URL CAPTs representing the fleet, surface, and air communities, and seven post-command fleet support CAPTs representing a variety of subspecialties serve on the board. Once screened, fleet support officers remain screened for the rest of their Navy career. The board may descreen officers currently screened due to declining performance.

Each fleet support officer gets three consecutive annual looks for command. Promotion year group quota allocations are based on projected promotion year group size, tour length, an annual fills. If an officer fails to select for CO/XO, there is no negative career impact. However, if a member declines a CO/XO assignment after screening, they receive a letter in their official service record per MILPERSMAN 1300-020. Officers may voluntarily withdraw their name from being screened via formal letter, but this letter is placed in their service record. All officers successfully screened for command will receive a command assignment.

Fleet support officers have distinct career paths to command. They must also complete a successful command tour before they are promoted to CAPT. XOs of Navy Brigs and Naval Recruiting Districts (NRDs) who complete a successful 18-month tour,

fleet up to CO for an additional 18-months. Most CO and XO tour lengths range from two to three years. CO/XO billets are filled by seniority. Key factors required for successful command screening include: PRD, variety of assignments, performance, and good FITREPS specifically good remarks in the comment's section and high marks in the leadership block. The board looks at the member's reporting senior cumulative average, and ensures that the "Recommended for CO/XO" block is checked. Completion of a master's degree is a plus. Certain command billets require specific subspecialty codes, i.e., financial management, education and training, etc. Fleet support officers selected to command billets attend the PCO/PXO course, and the shore installation management and senior officer legal courses if required. Fleet support officers in operational commands receive special command pay.

4.   Judge Advocate General (JAG) Corps

The JAG Corps community is made up of approximately 760 officers. The JAG Corps does not hold a formal command screening board. The senior assignment officer prepares the command slate for the upcoming assignment cycle based on command vacancies, member's PRDs, and individual member's service record. The Judge Advocate General of the Navy approves the final command slate. CDRs and CAPTs can serve in XO billets; only CAPTs can serve in CO billets. A member serving as an XO can serve as a CO, but not in back to back tours (different assignment in between). Back to back XO assignments are not career enhancing. JAG Corps officers can voluntarily withdraw their name from CO/XO positions with no negative impact to their careers. The typical career path to command for a JAG Corps officer consists of:

- 0 - 2 years (training);
- 3 - 10 years (sea tour, Naval Legal Service Office (NLSO)/Trial Services Office (TSO), staff judge advocate (SJA));
- 11 - 16 years (department head/OIC NLSO, afloat SJA, DC tour, instructor);
- 16 - 22 years (XO NLSO, major staff SJA, judge, Naval War College (NWC);
- 22 - 30 years (CO NLSO, OJAG tour, appellate/circuit judge, fleet SJA).

Factors influencing the assignment of command include the completion of graduate education, history of assignments (taking difficult assignments), certain subspecialty codes, service reputation, and good performance as indicated by the officer's FITREPS. CO and XO orders are written for three years, but most COs turn over in two years. Individuals selected for command assignments attend PCO/PXO course and visit the Office of the Judge Advocate General of the Navy (OJAG) to receive prospective command briefs. JAG Corps officers serving in command assignments are not eligible for special command pay.

5. Meteorology/Oceanography (METOC) Community

The METOC community is made up of approximately 400 officers and maintains eight CO billets and five XO billets for CDRs; and nine CO or CO equivalent billets for CAPTs. The METOC community holds a formal administrative command screening board each year that is included on NAVPERSCOM's annual selection board schedule. The president of the board is either the Oceanographer of the Navy, or the Commander, Naval Meteorology and Oceanography Command (NMOC). Four Restricted Line (RL) special duty (Oceanography) CAPTs serve as board members. The board may descreen officers currently screened due to declining performance.

Command tour lengths range from two years for COs to three years for XOs. XOs do not fleet up to COs. METOC officers can voluntarily have their name removed from the screening board eligible, but must do so in writing and the letter is placed in their official service record. Officers who decline a CO/XO assignment after screening receive a letter in their official service record per MILPERSMAN 1300-020. Screening for command billets occurs over a three-year cycle that begins when the officer is selected for CDR. METOC officers receive three consecutive annual looks for command. Officers not screening for command after three looks will no longer be considered for command and most likely will not make CAPT. All officers screened for command are not guaranteed a command billet due to the limited number of opportunities.

The METOC community has adopted a defined career path to command. Sea duty, surface warfare qualifications, documented performance and comments related to command potential and leadership must be included in the FITREP. Selection quotas for the command screening board are derived from dividing the number of command and command equivalent tours by the average command tour length. The senior assignment officer develops the command assignment slate. The Commander, NMOC has final approval on command assignments. METOC officers can move from an XO to a CO billet, but this is not encouraged due to the limited number of command opportunities. Officers in receipt of orders to command attend PCO/PXO course. METOC officers do not receive special command pay.

6.   Submarine Warfare Community

The submarine warfare community holds a formal administrative command screening board each year that is included on NAVPERSCOM's annual selection board

schedule. There are a total of 94 command positions (58 fast attacks, 18 Tridents, 18 other) in the submarine warfare community. A Flag officer serves as president of the board. The remaining board consists of twelve to thirteen CAPTs who represent a variety of commands and must have served previously as a submarine CO. Submarine warfare officers can voluntarily withdraw their name from command screening, however, these officers will not likely be promoted or offered career-enhancing assignments in the future. Submarine warfare officers are eligible for XO screening as LCDRs during their 9-11 year career mark, and are eligible for CO screening as CDRs during their 14-16 year career mark.

The board rescreens all previously command-screened officers first, but only officers with significant performance deficiencies since their initial screening. Each service member gets three yearly looks by the XO and CO screening board. The submarine warfare community has a command plan, and as such, the board precept provides the board with selection quotas. The board selects approximately 20 percent of first year eligibles, 30 percent of second year eligibles, and 50 percent of third year eligibles. Eligible XOs get a fourth look and are included in the third year eligible group. If a submarine warfare officer does not screen for XO after three looks, they lose their incentive nuclear power bonus and may have to pay back bonus money paid from the time the command screening board convened in early October. Those screened for XO can keep their nuclear power bonuses for up to 15 years. CO screened officers' keep their nuclear power bonuses for up to 20 years.

CO and XO tours range from 20 to 22 months in length. Submarine officers usually complete one CO and one XO tour, but not usually back to back. Officers

currently serving as XOs can screen for CO. Submarine warfare officers receive special command pay in operational billets. Selection for command screening involves a variety of factors with performance as the key factor. Other factors include diversity in career assignments (attack submarines (SSNs), or fleet ballistic missile submarines (SSBNs)), completion of graduate education while serving on shore duty, and completion of arduous shore duty assignments. Officers in receipt of orders to command attend submarine PCO/PXO course in New London, Connecticut, attend training at the Naval Research Laboratory in Washington, DC, and complete three months of tactical training.

7.   Supply Corps (SC)

The SC does not hold a formal command screening board. CDRs usually serve in XO positions and CAPTs usually serve in CO positions. There are a few LCDR CO billets. Each year the senior SC assignment officer reviews upcoming CO vacancies as approximately one-third to one-half of command billets vacate during an assignment cycle. SC assignment officers try to match experience with billet types, i.e., CO or XO of an aviation supply depot should have prior aviation experience. The senior assignment officer meets with the Flag SC Chief to review the CAPT command slate. Serving as a CO is not necessarily a ticket punch for SC officers. Other billets, such as department head afloat, are more career enhancing. CDRs will not usually make CAPT unless they have been selected by the CDR Sea Duty Selection Board earlier in their career. XOs are normally CDRs who have not completed their sea duty. Other SC assignment officers put together the CDR slate, which includes XO assignments. Officers may turn down command assignments with no negative impact to their careers.

Some individuals are requested by name for command assignments. SC officers in receipt of orders to command attend PCO/PXO School. Assignment officers also ask gaining commands what training COs/XOs need before they report onboard. Most COs have no prior experience as XOs. SC command tours range from two to three years. Assignment officers try to avoid lateral moves (CO to CO job, XO to XO job). The typical career path for a SC officer includes two to four sea tours, one advanced education tour; two shore tours, and one major tour (fleet support, headquarters, policy, OCONUS).

8. Surface Warfare Community

The surface warfare community holds separate LCDR and CDR formal administrative command screening boards each year and both are included on NAVPERSCOM's annual selection board schedule. The LCDR command screening board consists of one flag officer and nine to thirteen post command CAPTs and CDRs who represent a variety of ship platforms. The CDR command screening board consists of three to four Flag officers and ten CAPTs who represent a variety of ship platforms. LCDRs become eligible for command screening at their 10-13 year career mark and CDRs become eligible for command screening at their 13-16 year mark. The senior surface warfare community leadership determines command selection percentages each year based on the community's needs. LCDRs receive up to three annual looks for command and CDRs receive up to four annual looks for command. The board may descreen officers currently screened due to declining performance.

Officers can screen into one of three categories: command afloat, command ashore and command other. Selection for command by ship type usually falls out

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naturally between the various types of ships. LCDRs and CDRs whose records are not strong enough to screen for ship-specific platforms, but who are considered strong enough to serve in other challenging assignments may screen to XO or CO of "other" during their final look. An officer who dos not select for XO after three looks will not screen for CDR command, and an officer who does not screen for CO after four looks will most likely not make CAPT. Command tour lengths range from 15 to 20 months. Surface warfare officers can voluntarily withdraw their name from the command screening board, but receive a mark in their service record and most likely will not get promoted to the next rank.

The typical career path to command for surface warfare officers consists of:

- 0 - 1 year (training);
- 1 - 4.5 years (first sea tour/division officer);
- 4.5 - 7.5 years (first shore tour, postgraduate school);
- 7.5 - 10.5 years (second sea tour/department head);
- 10.5 - 13 years (second shore tour);
- 13 - 14.5 years (XO tour);
- 14.5 - 17.5 years (third shore tour);
- 17.7 - 19.5 years (CO tour);
- 19.5 - 23 years (fourth shore tour, major staff, joint tour);
- 23 - 25 years (major command).

Selection to command is a result of several key factors: sustained superior performance at sea and ashore in competitive assignments, early and consistent recommendation for command at sea, consistently strong break-outs versus at sea contemporaries, and successful department head tours. Once an officer is screened, they are essentially guaranteed orders to command. Officers who decline a CO/XO assignment after screening receive a letter in their service record per MILPERSMAN 1300-020. Assignment officers seek to match the right person for the right job. The

prospective command slate is prepared by the surface warfare assignment officers then forwarded to the type commanders and the Office of the Chief of Naval Operations, Surface Warfare Division (N76) for final approval. Officers assigned to operational command assignments receive special command pay. Officers in receipt of orders to command attend PCO/PXO course, XO leadership school (if applicable), and specific ship type training.

D. CIVILIAN HOSPITALS EXECUTIVE MANAGEMENT SELECTION PROCESS

A brief comparison of the process for selecting CEOs and COOs of civilian hospitals is provided in order to broaden the scope of analysis. Although the civilian healthcare sector works primarily in a "for-profit" environment, it seemed beneficial to compare the two. There are numerous articles and books addressing such related topics as hospital CEO turnover, finding the perfect hospital CEO, physician executives, and attracting top executives. However, there is not much information on hiring hospital COOs, or on nurses serving in hospital CEO and/or COO positions. The term "nursing executives" (NE) in the civilian sector is comparable to the Director for Nursing positions in Navy MTFs. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) mandates that NEs actively participate in the hospital's leadership functions (Dwore, Murray, Fosbinder, & Parsons, 2000). The military healthcare system (MHS) is the only system that separates dental activities into stand-alone organizations and as such, no civilian comparison was conducted on COs/XOs of Navy DTFs. Interviews (using electronic mail) were conducted with the CEO, Dundy County Hospital located in Benkelman, Nebraska, and the Vice President (VP), Kaweah Delta Health Care District

(KDHCD), located in Visalia, California, to obtain their perceptions of their selection process.

Wilson and Stranahan (2000), describe the typical CEO as the person "entrusted with the fulfillment of the hospital or healthcare system mission in addition to his or her responsibility to improve the health of the community." This description is almost identical to the Navy description of a MTF CO. The challenges facing civilian hospital CEOs also appear remarkably similar to challenges faced by MTF COs, including: planning for uncertain futures, managing resources, promoting services, dealing with competition, and conforming to federal, state, local and healthcare industry mandates (Wilson & Stranahan, 2000).

The Navy healthcare system is considered a closed system, in that there is no lateral entry into Navy Medicine executive management positions. All potential COs and XOs are produced from within the system. Most Medical Department officers enter the Navy as Ensigns (ENS) or Lieutenants (LTs) and if they remain in the system for 18-25 years, they move through the promotion structure to the rank of CAPT. Eventually these officers are groomed and may be selected to serve as COs/XOs. In comparison, the civilian healthcare market is an open system. CEOs and COOs can either be selected from within, or from outside the organization. A board of directors typically governs civilian hospitals, and is usually composed of prominent community members that serve on the hospital board for a specified term, e.g., three years. The governing board is tasked with the responsibility of selecting the hospital's next CEO and, in many cases is intimately involved in the selection of the hospital COO.

CO and XO turnover in a Navy MTF is controlled by mandates and executed every two to three years. Civilian hospital CEO turnover rate averaged 10.6 percent between 1998 and 1999, down 6.3 percent from the following year (ACHE homepage, 2000). Research indicates that civilian CEO and COO turnover is a function of hospital characteristics (number of beds, number of services offered, etc.) and market characteristics (geographic location, competition, etc.). Simply stated, some hospitals are more challenging to run than others and are more vulnerable to executive turnover (Wilson & Stranahan, 2000).

The most common characteristics leading to selection for a hospital CEO position include: a master's degree in healthcare administration or business administration, at least four years of experience as a CEO or COO of a hospital, and exposure in areas such as board relations, physician relations, community relations, hospital operations management, team building, economics, and public policy (Cole & Hageman, 1995). The traditional hospital CEO career path begins by taking junior and midlevel management positions, advancing to assistant or associate administrator positions, serving as a COO, then advancing to CEO (Parsons, Gustafson, Murray, & Dwore, 1997). Physician executives have been visible in the healthcare sector for some time and bring with them an appreciation of the medical care process, the physician-patient relationship, and the difficulty of the quality/cost tradeoff at the individual patient level (Kindig, 1997). In 1994, the American Medical Association (AMA) noted that 2.52 percent of all active physicians listed management as their primary professional activity (Kindig, 1997).

There are several options hospital boards and CEOs have in selecting new CEOs and COOs. Three of the most common include the use of an executive search firm, a pro tem hospital committee, and develop healthcare executives from within the hospital. Selecting a new CEO can be a slow, time-consuming process. Executive search firms have the experience and resources to ensure that hiring deadlines, and the hospital's needs are met. They can also evaluate any internal candidates on an objective basis. Hospital boards/CEOs may put together a formal search committee representing board, senior management, and medical staff levels of the organization to select new CEOs/COOs.

Developing healthcare executives from within the hospital takes years. The VP of KDHCD came to his current facility as a graduate intern in 1980. After a successful 20-year track record of working with the administrative team, the medical staff and the board, he was recently selected to become the CEO of KDHCD effective September 2001 (electronic mail from VP, KDHCD, 21 February 2001). Hospital boards that cultivate existing talent must ensure that the leadership and organizational structure create opportunities for potential managers to be promoted into CEO positions. CEOs can help junior healthcare executives develop their skills and talents by supporting them in educational program attendance, encouraging seminar and training experiences, increasing their span of responsibility, and providing autonomy as a way of developing decision-making skills (Parsons, Gustafson, Murray, & Dwore, 1997). However, existing talent is not always available. As one current hospital CEO stated, "the talent pool is very limited in rural America, you unfortunately have to recruit from outside the walls of the organization. It would be a wonderful luxury to have this capability, but not many

healthcare executives want to work in rural hospitals based on the negative perceptions of location, constant financial and economic concerns, and ongoing recruitment of quality medical staff" (electronic mail from CEO, Dundy County Hospital, 19 February 2001).

Another option for the board of directors to consider, which is also an emerging trend, is to contract with a healthcare management firm to run the hospital from top to bottom. However, this option can have some negative points. As one CEO who recently replaced a management firm noted, "the board wanted someone to come in and clean house, lead, direct, organize, mentor, educate not just the staff, but the board and the community...they (management group) were trying to be all things for all people and never took the time to develop a strategic plan" (electronic mail from CEO, Dundy County Hospital, 19 February 2001).

This chapter described and compared the Navy Medical Department's command screening process, eight other Navy line and staff community's command screening processes, and the civilian healthcare selection process for CEOs and COOs. Each group has command screening/selection processes in place that were developed over time to meet their own unique needs, organizational culture, and external environment. Navy Medicine has an intuitive sense of how well their command screening process is functioning. By comparing command screening/selection processes of other organizations, Navy Medicine can assess if their own processes are efficient and effective, learn from their counterparts in the military and civilian sector, and determine if there are better ways to carry out this process.

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V. COMPARISON OF ORGANIZATIONAL MODELS WITH THE COMMAND SCREENING PROCESS

This chapter compares Navy Medicine's command screening process with organizational models and tools described in Chapter III. The five models used for analytic comparison include: Mintzberg's Organizational Model, Systems Model, Elite, Incremental, and Bureaucratic-Politics models. Stakeholder analysis and strengths, weaknesses, opportunities, and threats (SWOT) analysis are also provided.

A. MINTZBERG'S ORGANIZATIONAL MODEL APPLIED TO NAVY MEDICINE

Mintzberg's organizational model will be used to analyze the structure of Navy medical and dental treatment facilities (MTFs and DTFs). Structure in this context refers to the basic grouping of activities and people, how these groupings are integrated, and what integrating devices are used. MTFs and DTFs are commands where stakeholders, referred to in this study as the target group, potentially serve as commanding and executive officers (COs and XOs).

Mintzberg contends that organizations fall into one of five configurations: simple structure, machine bureaucracy, professional bureaucracy, divisional form, and adhocracy. Organizations differ from each other based on how five basic structural components, interact with one another (operating core, strategic apex, middle line, technostructure and support staff). The simple structure is based on direct supervision in which the strategic apex is the dominant component. The machine bureaucracy is based on standardized work processes in which technostructure is the dominant component. The professional bureaucracy, on the other hand, is based on standardized skills in which the

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operating core is the dominant component. In the divisionalized form, managers in the strategic apex directly supervise the work of subordinates. Lastly, the adhocracy is based on teams of professionals from the operating core, support staff, and technostructure relying on informal adjustment to coordinate their efforts (Mintzberg, 1993). An important thing to note is that there is no one pure organizational form, rather, an organization can exhibit the traits of more than one category, but in many cases one form dominates.

1. MTFs/DTFs as Professional Bureaucracies

The configuration of a professional bureaucracy describes MTFs and DTFs. The largest structural component is the operating core, made up primarily of professionals (doctors, nurses, technicians, and dentists). These professionals rely on skills learned both from advanced education and experience to accomplish their work. Members of the operating core tend to be self-organized learners. They attend conferences, professional meetings and continually retrain to maintain their complex skill set. Professional bureaucracies use highly trained specialists for the operating core, and give them considerable control over their work. With relative autonomy, professionals work with; yet independent of their colleagues, and focus on the clients they serve (Mintzberg, 1993).

Unlike a machine bureaucracy, which generates and enforces its own standards, a professional bureaucracy is more self-governing. Professional associations standardize the skills and knowledge required of their members. Professionals in the operating core may oppose the intrusion of the technostructure in their work environment, particularly if it threatens their autonomy, and attempts to dictate performance standards. Professional

bureaucracies change by controlling entrants into the profession, introducing new knowledge from research, and peer pressure to maintain and update skills (Mintzberg, 1993). The hierarchical structure is graphically depicted in Figure 11. The following sections describe the components of the MTFs and DTFs hierarchical structure using Mintzberg's professional bureaucracy framework.

a.   Operating Core

The operating core for MTFs and DTFs is doctors, dentists, nurses, pharmacists, physical therapists, corpsman, dental technicians, and others who provide direct patient care. The operating core is the largest structural component relevant to MTFs and DTFs. Most professionals obtain their training and skills from advanced education. Academic requirements range from four to eight plus years of college, graduate, and terminal degree programs. Medical and nursing schools for doctors and nurses, and graduate programs for health care administrators all focus on providing extremely specialized skills. Many positions fall under peer review, exemplifying how a professional core controls membership. Several direct care providers are required by law to obtain continuing education units (CEUs) to maintain their license to practice medicine or care for patients. If professionals do not maintain certain skill levels, legal bodies can intervene and prevent a provider from practicing medicine. The Medical Corps (MC) has medical exams allowing providers to be board certified, and the Nurse Corps (NC) has exams for Registered Nurses (RN). Medical professionals work fairly independent of their colleagues but closely with their patients, where they strive to develop provider/patient relationships. MTFs and DTFs are somewhat inflexible due to the prevailing nature of a professional bureaucracy.

Figure 11. Mintzberg's "Professional Bureaucracy"

Strategic Apex

Commanding Officers   Executive Officers

Executive Steering Council

Techno-Structure

Education & Training
Comptroller
CIO
Command evaluation

Support Staff

Facilities
Manpower
Patient Administration
Operating Management

Middle Line

Directors
Department Heads
Division Officers

OPERATING CORE

Medical Corps
Dental Corps
Medical Service Corps
Nurse Corps
Hospital Corpsman
Dental Technicians

After: Mintzberg, H., Structure in Five, Public Policy 1993.

b.   Strategic Apex

The strategic apex for MTFs and DTFs organizational structure consists of the CO, XO, and Executive Steering Council (ESC). These positions/groups ensure that MTFs and/or DTFs execute its mission. They are responsible to the Chief, Bureau of Medicine and Surgery (BUMED) on the medical/dental side and to the Responsible Line Commander (RLC) for local support of the base population and a defined catchment area. Middle line managers, who transmit authority from the top to the bottom e.g., hospital administrators, join the strategic apex with the operating core.

c.   Middle Line

Middle line manages link the strategic apex to the operating core. They provide direct supervision that the strategic apex cannot perform due to the magnitude of work and complexity of Navy Medicine. The middle line includes directors of different sectors of the hospital. The directorate usually consists of several different departments run by department heads and division officers. These positions are for a specific service or common service line, e.g. surgery department with orthopedics and general surgery divisions.

d.   Technostructure

The technostructure affects how the organization accomplishes its work. Typically, members in this group design work and train people who perform work functions, but do not perform the core work themselves. Examples include the education and training departments, comptroller, command evaluation officer, and Chief Information Officer (CIO). They coordinate with the operating core on types of instruments and procedures to use for their work positions. Once the technostructure

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establishes the technologies and procedures for the work force, they may coordinate and standardize training. In Navy Medicine's professional bureaucracy, the technostructure is smaller than the operating core.

e. Support Staff

The support staff are specialists who provide support outside the operating workflow. This work includes facilities management, operating management, patient administration, and manpower management. These are the administrative positions that provide services to the MTFs and DTFS that are made up of personnel mainly from the Medical Service Corps (MSC) and certain ratings from the Hospital Corpsman and Dental Technicians communities.

B. SYSTEMS MODEL APPLIED TO NAVY MEDICINE

Most organizations are dependent on the external environment for resources, people, information, and feedback. Systems theory considers the external environment and a set of organizational attributes called design variables that generate results (culture, outputs, and outcomes). Systems theory recognizes the significance of adapting to external forces as a measure of effectiveness. An organization is one part of a dynamic interplay of components. Organization leaders interface with the environment and set direction. Managers often intervene in the terms of structure, people, tasks and technology to achieve desired results (outputs and outcomes). The Systems Model as it pertains to Navy Medicine's command screening process is illustrated in Figure 12.

Figure 12. Organizational Systems Model

Inputs → **Throughput** → **Results**

Design Factors

ENVIRONMENT/CONTEXT
(external to system)
- Congress
- Economic Conditions
- Military-civilian relations
- Medical Technology Pace Change

KEY SUCCESS FACTORS
- Accurate, Predictable & Timely Information about Individuals being screened

SYSTEM DIRECTION
- Directives
- Instructions
- Manpower Requirements
- Policy
- People Goal from Navy Medicine Strategic Plan

TASKS/JOBS
- Self-Selection
- Record Review
- Formal Board

TECHNOLOGY
- EMPRS
- OAIS

STRUCTURE
- BUMED
- MTFs
- DTFs
- NAVPERSCOM

PEOPLE
- 1,248 Medical Department Captains (Target Group)
  - 569 Medical Corps
  - 306 Dental Corps
  - 206 Medical Service Corps
  - 167 Nurse Corps
- Decision Makers
  - SG & Corps Chiefs
- Implementers
  - Medical Assignment & Placement Branch of NPC
  - Corps Chief staff
- Influencers
  - ASD(HA)
  - Congress
  - Line Navy
  - Corps Chiefs
  - CNP & DCNP

PROCESS/SUBSYSTEMS
- Career Management
- Career Training
- Marketing of Positions

CULTURE
- Professional Bureaucracy
- Team Orientated
- Semiautonomous Workforce

OUTPUTS
- A pool of qualified Screened Captains
- Billets Filled
- Career Management

OUTCOMES
- Healthy Force
- Optimized Manpower Resource Allocation
- Management Efficiency in MTFs & DTFs

1.   Environment/Context

The first element in the Systems Model is the external environment and context of the organization.   The organizational environment includes relevant socio-economic, political factors and events outside organizational boundaries. Context refers primarily to setting direction and key success factors.

a.   *Political*

The major political influences concerning the command screening process are congressional.   The increasing cost of health care and pressure from military beneficiaries forced congressional interest and involvement. Congressional legislation passed in fiscal years 1993, 1996, and 2001 included funds earmarked for MTF/DTF CO/XO development.

b.   *Economic*

Economic conditions outside the military affect entering, stay, and leave decisions of medical personnel. When the economy is booming, recruiting and retaining qualified health care professionals becomes more difficult. The civilian labor market directly impacts the pool of eligible candidates for command screening. The demand of health care professionals in the civilian marketplace may be stronger due to perceived and actual salary differences.   In short, external economic factors affect command screening and selection by affecting the decisions of highly qualified officers to stay or leave the Navy.

c.   *Social*

The researchers perceive a growing gap between military-civilian relations since the end of the cold war. The military in general has been the target for a list of

correctable actions. Practically every function of the military has been under scrutiny and cost justification. The Military Health System (MHS) is no exception. The advent of TRICARE, which is a managed care approach to the health care delivery system, placed MHS in the negative light of public perception. Beneficiaries complained that access to care was more difficult under TRICARE. This initiated some negative public perceptions of the MHS. The Assistant Secretary of Defense, Health Affairs (ASD(HA)), became involved in the quality of COs and XOs through a tri-service approach to executive medicine education program.

d. Technological

The medical field is very technologically driven. There are technology changes in the medical field on a regular bases with introductions for medical equipment and procedures. The professional staff, which is employed in the medical field, tends to have preference to use the latest equipment and newest techniques. This driving force can be a deciding factor for certain individuals to stay or leave the military for a career path.

2. Key Success Factors

For the command screening process to be successful there needs to be accurate, predictable, and timely information about the individuals being screened. The Officer Summary Record/Performance Summary Record (OSR/PSR) and fitness report (FITREP) are the largest vehicles providing this information. The OSR/PSR is made up of cumulative fitness report scores, schools attended, additional qualification designator (AQD), and degrees. The FITREP is the document that the command screening board uses to review individuals' past performance and history of assignments.

3. System Direction/Strategy Formulation

The next element in organization design is the system direction/strategy formulation element. This element includes defining the organization's mission, specifying objectives, establishing short and long-term goals, developing strategies and setting policy directives. Overall systems direction and strategy formulation are determined by the following attributes:

a. *Mandates*

Mandates are what an organization must and should accomplish including rules and policies, as well as federal, state and local laws, codes and regulations. Mandates are constraints to the organization and must be considered as such during the direction setting/strategy formulation phase. Organizations must be aware of all mandates affecting them, or be prepared to face significant penalties and ramifications. There are both formal and informal mandates (Bryson, 1995).

There are organizational mandates imposed from the highest levels in Department of Defense (DoD). For example, ASD(HA) mandates specific competencies individuals must have to serve as a CO/XO. The command screening board precept, Title 10, United States Code, SECNAVINST 1401.3 and the Officer Transfer Manual (OTM) govern aspects of the board process as well as Naval Personnel Command (NAVPERSCOM) guidelines and operating procedures.

b. *Values*

Values and shared beliefs are foundation concepts affecting how events and communications are interpreted and given meaning within the organization. Values impact motivation and culture. Shared values and beliefs can hold effective

organizations together, and conflicting values can cause disharmony and dysfunction. In general, values and beliefs emerge in an organization over many years, and can be explicit or tacit.

The Navy Medicine value system is based around service and scientific (medical) professionalism. Taking care of Sailors and Marines around the world embodies the service ethic. Values can be expressed in the different slogans that organizations espouse, i.e., "Fit to Bite...Fit to Fight."

c. Mission

The reason Navy Medicine exists is to support the deployment readiness of the uniformed services and promote, protect and maintain the health of all those entrusted to their care, anytime anywhere (BUMED web site, 2000).

d. Vision

The vision outlines what a company wants to be. Navy Medicine's vision is to provide superior readiness through excellence in health services.

e. Goals

There are four pillars, which house the stated goals for Navy Medicine: Force Health Protection, People, Health Benefit, and Best Business Practices. The command screening process fits under the People pillar. The specific goals of "Enhance Job Satisfaction and Career Development" and "Train to Requirements" are the goals in which the command screening process would match the needs of Navy Medicine.

f. Strategies

Johns (1992) defines strategy as "the process by which top executives seek to cope with the constraints and opportunities posed by the organization's environment."

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Strategies are the plans to attain outcomes consistent with the organization's mission and goals. Strategy can be looked at from three levels: (1) strategy formulation, or developing the strategy, (2) strategy implementation, or putting the strategy into action, and (3) strategic control, or modifying either the strategy or its implementation to ensure that the desired outcomes are attained.

There are six key areas linking the mission, vision, values, goals and objectives: service to the fleet, manage health not illness, TRICARE and readiness are inseparable, make TRICARE work, embrace best business practices, and enhance data integrity (BUMED web page, 2000). Providing service to the fleet is Navy Medicine's primary goal. Fleet readiness is the main reason for existence, and the health of Sailors and Marines has a direct effect on readiness. Serving the needs of active duty members is paramount, but caring for thousands of family members is also critical. A mindset is underway within the health care delivery system to focus on the whole patient and not just the medical problem. Wellness and health need to be addressed to promote prevention, not treatment.

Making TRICARE work is vital to the success of military health care. TRICARE is the system, which has been chosen to manage DoD healthcare. The need to understand and become an advocate of the managed care approach is a success factor for senior leaders. Finding ways to improve the current system and fostering teamwork to streamline high cost and improve patient satisfaction are also key success factors.

Embracing best business practices along with enhancing data integrity are fairly new to the healthcare industry. Since the emergence of tighter fiscal constraints within the healthcare arena, as well as DoD cut backs, the best use of resources is

penultimate to the success of Navy Medicine. The changing demographics of military beneficiaries provides a challenge in which Navy Medicine must examine processes, embrace appropriate new technology and standardize to limit the amount of resources expended unnecessarily. Best business practices can be improved upon by measuring the appropriate outcomes. Defining success in healthcare is not always easy, but a reasonable premise is that superb leadership becomes increasing important.

4. Design Factors

The design factors are the components of an organization that impact its culture. They include tasks, technology, structure, people and processes/subsystems as defined below for Navy Medicine regarding the command screening process:

a. Tasks/Jobs

A task is typically defined as a unit of work, or a set of activities needed to produce some result. A job is a collection of tasks and responsibilities that an employee is responsible to conduct.

There are three main tasks/jobs associated with the command screening process. First, the members of the target group have the option of self-selection into the pool of individuals to be reviewed for command screening. This is done with a survey, which is sent out primarily from the Corps Chiefs' office. The Dental Corps (DC) administers their survey from NAVPERSCOM. This survey serves as a tool to determine the intent of the medical officer to screen for command. Once the intent of all the medical officers are determined to the satisfaction of the respective Corps Chiefs, record reviews for each person in the screening pool is undertaken. This is a check to make sure all the necessarily items are in a person's record prior to the formal board. The formal

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board takes place at NAVPERSCOM and is similar to a promotion board; there is a brief on each individual's record and then the floor is open for discussion on the record at hand. Once the discussion concludes, each member has an equal vote to determine if the applicant has the skills and abilities to be selected in the screened CO/XO pool.

b.   Technology

Technology refers to the workflow of the organization, the mutual support among the work units or activities in the work flow, and the physical facilities and equipment used to accomplish the work. The process by which inputs or information sources are transformed into outputs or services reflects an organizations technology.

Navy Medicine technology (selection) does not seem to be very different from other communities within the Navy as a whole. There are two main information systems, which house data on each person being screened. They are the Officer Assignment Information System (OAIS) and Electronic Military Personnel Record Information System (EMPRIS). These two information systems provide the board member with the information needed in the screening process to determine an individual's qualification. The workflow can be described as standardized with a process approach to reviewing the individual records in the command screening process.

c.   Structure

Structure refers to the basic grouping of activities and people, how these groupings fit the workflow, and how they are integrated. It includes the manner in which organizations divide labor into specific tasks and achieve coordination among the tasks.

The organizational structure of Navy Medicine is centralized with the Surgeon General (SG) and Corps Chiefs at the strategic apex of the organization.

Implementers are departmentalized and serve in support staff roles. Influencers fit in both the technostructure and support staff of Navy Medicine regarding the command screening process. The Corps Chiefs, when severing as an advocate for their corps, could also be called middle line linking the target group in the operating core to the strategic apex.

d. People

Organizations are dependent on the behaviors and performance of their employees. Labor cost typically consumes over 60 percent of an organization's resources. Organizational performance is tied directly to the capability of its people.

The command screening process is crucial to the morale and welfare of Navy Medicine. The CO and XO set the tone for how a majority of Naval Medicine personnel relate to their work environment. The screening process seeks the "best qualified," and a skill sought by decision makers is the ability to motivate. When one or two key people at a command have powerful influence over a person's job satisfaction and career retention, Navy Medicine needs the best leaders to run its facilities.

The target group consists of 1,248 Medical Department Captains (CAPTs) and Captain selects. The break down within the different corps are: 569 MC, 306 DC, 206 MSC, 167 NC (2000 data). This is a very talented group with very diverse career backgrounds. Each corps serves in a different capacity prior to screening for command. Their common thread throughout this group is serving others and providing the best health care for their beneficiaries. One of many gauges used to determine if the individual is prepared for command is a specified list of 40 competencies, which are universal among the other military medical services.

The decision makers, the SG and Corps Chiefs, are individuals who have gone through the process themselves in the past. Currently, all the members in the decision maker category have served as a CO and or XO at least once in their career. This group is very experienced and makes decisions on what is needed for the future in Navy Medicine. They perform strategic thinking for Navy Medicine and seek to select the "best qualified" medical officers for the future.

The main implementers are individuals who work at Medical Assignment and Placement Branch of NAVPERSCOM. These individuals are usually Commander (CDR) and above familiar with the manpower issues of Navy Medicine. They are the link between the other groups for the selection process to occur. They make sure the details of the command screening process are implemented and provide assistance to individuals or groups needing clarification. In general, Corps Chiefs initiate the process by sending out the surveys, which determine the intent of the potential candidate regarding self-exemption.

Influencers are different groups involved for different reasons. The main influencers are ASD(HA), Congress, Corps Chiefs, and NAVPERSCOM specifically the Chief and Deputy Chief of Naval Personnel (CNP/DCNP). ASD(HA) works alongside both Congress and line Navy. Congressional authority is concerned with the cost of health care since they are the pipeline for funding. The line Navy focuses on the quality of care that their sailors receive. ASD(HA) has influence on both of these issues and keeps abreast of both areas and reports to the appropriate party. The CNP and DCNP are influencers in the actual board processes and sub-processes. They determine and monitor board process and set parameters and guidelines for the administering of screening

boards. The Corps Chiefs are influencers in that they serve as advocates for their respective corps. They are connected with the members of their corps, and provide assistance and guidance to individuals seeking executive medicine as a career path.

e.   *Processes/Subsystems*

Process is best defined as a sequential function within an organization that enables it to successfully deliver its products and services. The processes and subsystems can link the design factors of the organization together.

The decision maker, implementers and influencers have definitive career paths for members to be successfully screened. The ability to communicate that career path/requirements to the target group population and giving them a clearer understanding of the process is the goal. Career management for Navy Medicine is crucial to the screening process. Individuals need to take personal action to gear their career towards executive medicine and be a successful candidate. Navy Medicine offers several avenues in which career advice and guidance can be obtained. Once a person has their goals aligned with the needs of Navy Medicine, as individual match can be made for both parties.

In order for individuals to successfully screen for command, the appropriate competencies need to be developed. Investing in career training is vital to this process. Seeking out opportunities to build the skills needed for serving as a CO or XO need to be in place to properly prepare potential candidates.

Positions need to be marketed. The process of planning and communicating the information for command screening is essential to attract quality applicants. There are two main methods to market the command screening process. The

web-based method on homepage sites for each of the corps as well as site visits from senior leadership of Navy Medicine and the Medical Assignment and Placement Branch of the Naval Personnel Command.

5. Culture

Schein (1992) defines culture as "a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid, and therefore, be taught to new members as the correct way to perceive, think, and feel in relation to those problems." Patterns create norms that define acceptable behavior from the top down.

Navy Medicine has several observable culture characteristics. Members seek to provide the highest quality professional care to all beneficiaries. The trait denotes both the nobility and sacrificing aspects of a medical community. The people in Navy Medicine are team-orientated and have a willingness to help others. Some potential CO/XO candidates have an extreme dedication to their clinical practice and may self-exempt from command. Some officers indicate a highly competitive nature, similar to the line community.

Navy Medicine is team-oriented in that it takes individuals from diverse backgrounds and places them in unique situations around the world, which require team efforts. There seems to be a strong sense of service among Navy Medicine as a whole. They appear willing to lay down their lives in order to save someone else's.

6. Outputs

Output is what the system offers or produces in terms of goods and/or services. Outputs can also serve as a measure of success for accomplishment of goals and

objectives, efficient and effective use of resources, and successful adaptation to a changing environment.

There are three major outputs in the command screening process. The input combined with the throughput results in a pool of "best qualified" Medical Department CAPTs ready to take command of MTFs and DTFs. The CO/XO billets that become vacant each year are filled with CAPTs who have completed formal command screening at some point in their career. The process also acts as a gauge to provide career management goals. The process sets the standard and determines what type of leaders will be in command for MTFs and DTFs in the future.

7. Outcomes

Outcomes refer to the implications/consequences of outputs for the stakeholders, and how these outputs are viewed in terms of the environment. Outcomes of the command screening process are that the "best qualified" individuals are serving in command positions to lead Navy Medicine into the future. In the MHS, COs/XOs are evaluated by the health status of the population in their catchment area. Medical and dental COs/XOs are judged on the readiness status of the active duty forces in their area of service. The Navy DC monitors 13 metrics to determine the dental readiness of the Sailors and Marines under a CO's purview. Medical has attempted to apply metrics to determine if COs/XOs are successful in their tours. ASD(HA) has implemented other metrics to measure CO/XO efficiency such as the primary care optimization model, TRICARE enrollments, patient complaints, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey scores, and MTF/DTF CO's FITREPS.

C.   ELITE MODEL APPLIED TO NAVY MEDICINE

The Elite model of decision-making assumes that the values and preferences of the few who govern a society or an organization dominate policy and strategy decisions. Elite theory assumes that society in general is uninterested when it comes to policy making, and as such, the governing few make policy decisions for the uninformed many. Public officials and administrators are primarily responsible for implementing the policies determined by the governing few (Dye, 1995).

As described in Chapter IV, there was not a formal command screening/selection board process established until 1989 as a result of the Medical Blue Ribbon Panel. The panel reported there were no identifiable prerequisites, career path or formal criteria to select and assign properly trained and proven personnel to leadership positions leading to command in the Navy Medical Department. Prior to 1989, selection to command was done by the SG with input from the Corps Chiefs. The selection process in this time frame corresponds with the elite model described by Dye (1995). Dye states that public policy may be viewed as the preferences and values of a governing elite, and that elites actually shape mass opinion on policy questions more than masses shape elite opinion. The few who govern, in this case the SG and the Corps Chiefs, made the selection policy based on their beliefs and preferences. Dye might conclude that the next SG will make command-screening decisions based on preserving stability within the Navy Medical Department.

The elite screening and selection process generated some negative perceptions by the late 1980s. The Medical Department command screening process was initially evaluated by an external entity, the Medical Blue Ribbon Panel in 1988. This may have

been a result of target group and/or benefactors of Navy Medicine complaining of the selection process by top Navy Medicine leadership.

Although the command screening process has been formalized and appears to be a much fairer process, the SG continues to make policy based on his beliefs and preferences. One particular policy initiated solely by the current SG was that one of the CO/XOs must be subject to peer review as a clinician at some point in their career. Medical Department officers who are not under peer review may perceive this policy as showing favoritism towards those with peer review.

D. INCREMENTAL MODEL APPLIED TO NAVY MEDICINE

The incremental model of policy making originated with political scientist Charles E. Lindblom (1979) who believed that there are various actors with conflicting values involved in policy-making and implementation. Because there are so many different actors involved there is often disagreement on which policy issues to address, or how goals should be pursued. As a result, decision-making produces policies that are similar to previous ones, i.e. incremental in nature.

Aspects of incrementalism describes public policy as a continuation of past government activities in terms of marginal modifications. When BUMED implemented a formal command screening board in 1989, there was likely disagreement among the decision makers, target group, implementers and influencers. In an elitist framework, the establishment of a formal command screening board circumvents elite power. As with some new policies, it probably took several years for the dust to settle, the leadership to change, and the masses to become more involved in the command screening process.

Looking back at the command screening process from 1992 to today, there have been three different SG's leading Navy Medicine. Replacing the SG leads to slight changes in the command screening process. The changes to the process have been to help one or more corps fair better in the selection process or to upgrade the board proceedings to current technological standards. Based on our research, including interviews with various stakeholders, it is easier to make minor changes to the process than major ones. Minor changes reduce conflicts; maintain continuity and aids in communicating one basic process to the target population.

The other contributing factor to an incremental change approach to this process is the rapidly changing state of the MHS. The early 1990s was the beginning of TRICARE, shifting Medical Department financial resources control from line Navy to ASD(HA) and the downsizing of the military. The decision makers did not have the time, energy or financial resources to re-engineer the command screening process. It was easier for Navy Medicine leadership to spend more time on other issues and leave the command screening process alone since it produced the desired results.

E.   BUREAUCRATIC-POLITICS MODEL APPLIED TO NAVY MEDICINE

In a bureaucratic-politics model there are no unitary actors. Decision makers cannot act alone. The decision maker must take multiple stakeholders' needs into consideration since many of these stakeholders can affect the outcome of any decision. Lobbyists may need to be consulted prior to some policy decisions. Policy changes may be carried out within existing laws and regulations, or they may require changes to existing laws and regulations. Regardless, stakeholders who can alter the laws and regulations should be consulted (Quade, 1995).

The bureaucratic-politics model is also applicable for describing the command screening process. A federal government panel evaluated the Medical Department command screening process because the researchers believe there were some complaints of favoritism and a selection process clouded in secrecy. In a true bureaucracy, power is shared among many. The formal process implemented in 1989 divided the power between the SG and Corps Chiefs with oversight by NAVPERSCOM. The target group and the implementers became more involved in the process and the influencers inherited more influence toward policy initiation. Each of the stakeholders had different objectives under the formal process and the result was a compromise to ensure the laws and regulations were followed, the target group had a clearer understanding of the process, and the implementers were more informed and involved in the process. The ultimately led to the decision makers marketing a goal of selecting the "best qualified" officers.

F.   STAKEHOLDER ANALYSIS APPLIED TO NAVY MEDICINE

One of the tools used to analyze the Navy Medical Department command screening process was a stakeholder analysis. A stakeholder analysis is used to identify an organization's internal and external stakeholders, reveal how stakeholders influence the organization and determine how important each stakeholder is to an organization. Bryson (1995) defines stakeholder as "any person, group, or organization that can place a claim on the organization's resources, attention, or output, or is affected by its output."

A stakeholder identification worksheet was used to determine the external and internal stakeholders involved in the command screening process. Figure 13 displays the results. Once all the stakeholders were identified a stakeholder map, Figure 14, was generated. A stakeholder map identifies the stakeholders groups who can affect or be

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affected by the command screening process. The purpose of the map is to determine the groups that have the potential to make a difference in the outcome of some course of action. The stakeholder map clearly demonstrates that many individuals and groups solicit an organization's attention, resources, and output (Bryson, 1995). Conducting the stakeholder analysis ensures that all stakeholders are identified, especially when stakeholders are physically distant from the organization.

The purpose of the stakeholder map is to identify the stakeholders in the command screening process. Our initial intent was to list all relevant stakeholders. Once all the stakeholders were identified, they were placed one of four groups based upon their respective stakes and or role in the command screening process.

Figure 13. Stakeholder Identification Worksheet

External Stakeholders

DoD(Health Affairs)

Naval Personnel Command

Lead Agent's

Congress

Department of Navy

TRICARE
Management Activity

Military Health
Beneficiaries

Executive Medicine
Education Program

Internal Stakeholders

Surgeon General MC Corps Chief

DC Corps Chief MSC Corps Chief

NC Corps Chief Medical Captain's

Medical Detailing/Placement

Military Health
Staff / Employees

U.S. Air Force

U.S. Army

Unrestricted Navy Line

Naval School of Health Sciences

After: Bryson, John M., Strategic Planning for Public and Nonprofit Organizations

Figure 14. A Stakeholder Map for Navy Medical Command Screening Process
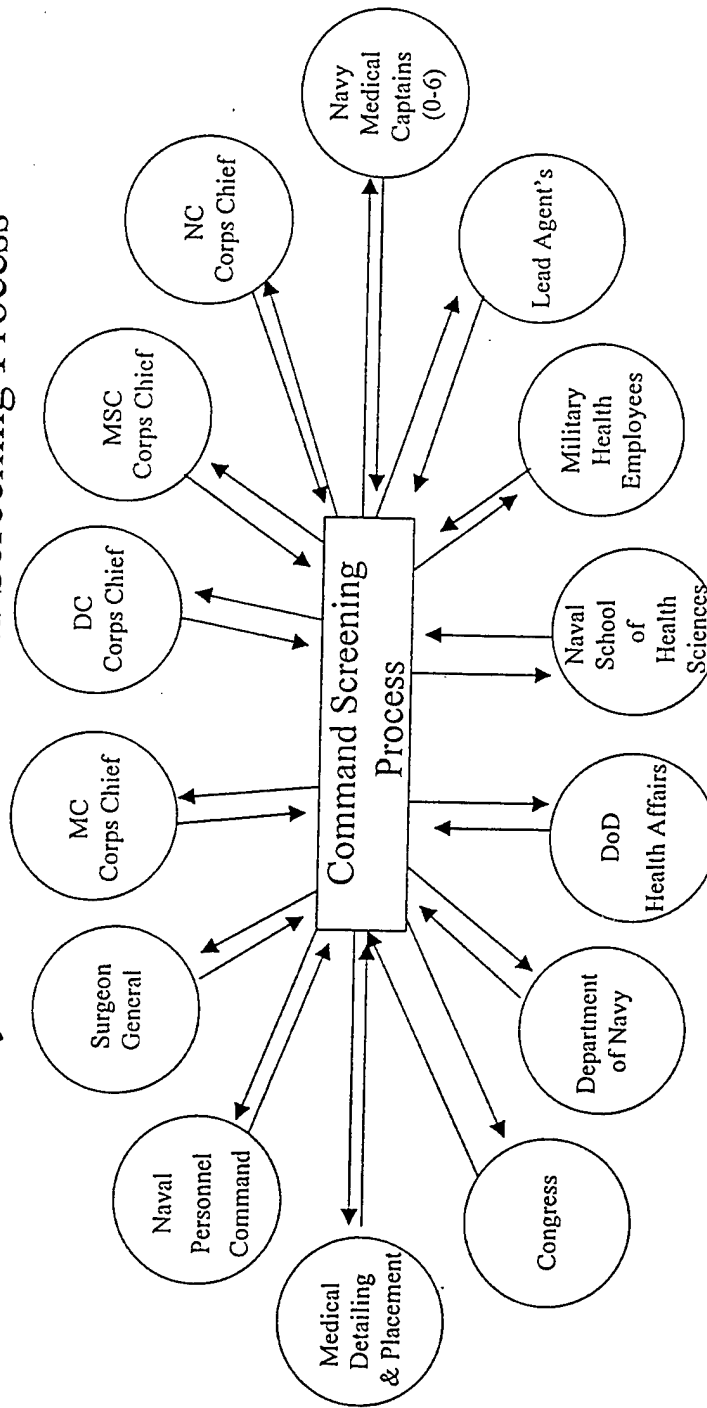
After: Bryson, John M., Strategic Planning for Public and Nonprofit Organizations

Quade (1989) identifies four main groups of stakeholders, which include: target group, implementers, decision-maker(s), and influencers. The target group includes individuals or groups at which the policy is aimed. The implementers are the individuals or groups that are responsible for carrying out the policy initiative. The decision-maker develops and/or approves which policies are implemented in the organization and the influencers include individuals or groups who will have a direct influence on the policy decision (Quade, 1989).

1. Target Group

Quade defines the target group as the group at which the policy is aimed. In the case of the Medical Department command screening board, policies that provide process direction and selection procedures are targeted at the active duty CAPTs in each of the four Corps.

a. Medical Corps (MC)

MC CAPTs come from a variety of backgrounds and professions, each with varying degrees of administrative and clinical experience. MC officers represent a broad range of specialties from family practice to undersea medicine. MC officers can be looked upon as proverbial students. To become a physician, it takes four years of undergraduate school, four years of medical school, and three to eight years of internship and residency, depending on the specialty selected. Admission to medical school is highly competitive. Physicians seeking board certification by the American Board of Medical Specialists (ABMS) or the American Osteopathic Association (AOA) must take a written and oral exam after they complete their residency training. There are 24

specialty boards, ranging from allergy and immunology to urology (Education Planet web page, 2000).

All States, the District of Columbia, and U.S. territories license physicians. To be licensed, physicians must graduate from an accredited medical school, pass a licensing examination, and complete one to seven years of graduate medical education. Physicians must renew their medical license on a recurring basis. Each State has different requirements and medical license renewal periods vary between once a year to once every three years. States also differ on continuing education requirements for physicians. Currently, 32 States require that physicians obtain between 12 to 50 CEUs per year to renew their medical license. Nineteen States, including the District of Columbia, require no CEUs for medical license renewal (Education Planet web page, 2000).

Most MC officers enter the Navy at a minimum rank of Lieutenant (LT) with two to three years of credit based on education and/or prior work experience. Other MC officers with extensive civilian work experience and/or highly needed specialty skills can enter the Navy at the Lieutenant Commander (LCDR) or Commander (CDR) rank. MC CAPTs may have as little as 10 years of active duty service to over 30 years of service and all are eligible for Command Screening. MC CAPTs have a choice of several career tracks including executive medicine, clinical, operational, education/academic, and research. Those taking the executive medicine career track usually serve as department heads (DHs) and later move into directors of hospital services (ancillary, clinical, surgery, medicine). However, MC officers who select other career tracks remain eligible for command screening.

b.   Dental Corps (DC)

To become a Navy Dentist, an individual must be a graduate of a dental school accredited by the American Dental Association (A.D.A.) (Navy Recruiting Command web page, 2000). Dental schools require a minimum of two years of college-level pre-dental education. Dental school is four years in length and upon completion the individual is awarded the degree of Doctor of Dental Surgery (D.D.S.) or the Doctor of Dental Medicine (D.M.D.). All 50 States and the District of Columbia require dentists to be licensed and 17 States require dentists to obtain a specialty license before practicing as a specialist. Requirements include two to four years of postgraduate education and, in some cases, completion of a special state examination. States also vary by CEUs for licensed dentists, which range from zero per year to 75 hours every five years (Education Planet web page, 2000).

DC CAPTs also enter the Navy anywhere from the LT to CDR rank depending on the level of civilian experience and specialty field. DC CAPTs years of service also range from 10 to over 30 years and they have several career track choices including executive medicine, clinical and operational. Those taking the executive medicine career track usually serve as department heads, directors of small dental clinics, and later move into staff positions at Navy Medicine headquarters or Force Dental Officers. As with MC officers, DC officers who select other career tracks remain eligible for command screening.

c.   Medical Service Corps (MSC)

MSC officers are a diverse group of individuals who represent over 32 different specialty fields including health care administrators (HCAs) and health care

scientists (HCSs). Approximately 58 percent of the MSC community is made up of HCA officers. HCA applicants to the Navy must have a master's degree with a major in health care, hospital or health services administration, or a master's in Business Administration (MBA) with a concentration in health care administration. MSC HCS officers can enter the Navy, depending on the specialty, with a bachelor's degree (Medical Technologist, Environmental Health Officer, Industrial Hygienist), master's degree (Physician Assistant, Pharmacist, Research Psychologists), or a doctorate degree (Clinical Psychologist, Podiatrist, Entomologist) (Title 10, Program Authorization, 2000).

MSC officers can enter the Navy between the ranks of Ensign (ENS) to LT, depending on prior education and work experience credit. The MSC is the officer Corps with the highest percentage of prior enlisted members. This high representation of prior enlisted rises the average years of service of newly commissioned MSC ENS to approximately seven years. The average CAPT MSC has over 19 years of service when they are eligible for the command screening board. MSC officers also have several career tracks including executive medicine, clinical, operational, academic and research. However, many HCS officers must move into administrative positions, as they become more senior CDRs and CAPTs to be successful at the command screening board. More senior MSC officers can serve as department heads and Directors for Administration (DFA) at medium to large size MTFs, Officers-in-Charge (OICs) of medical clinics, and COs/XOs of medical battalions. As with the other Corps, all MSC CAPTs are eligible for selection at the command screening board.

d. Nurse Corps (NC)

Admission to the Navy NC requires that an individual be a licensed registered nurse (RN) and a graduate from an accredited U.S. bachelor (B.S.N.) or master's nursing program. B.S.N. programs offered by colleges and universities can be completed in four or five years. Graduate programs preparing executive level nurses usually last one to two years. Nursing licensure requirements vary by state. A state board of nursing issues a nursing license. Appointed by the governor, the board customarily consists of practicing nurses, nurse-executive, educators, specialists, and consumer representatives who set standards for acceptable nursing practice in their state. The nurse's license ensures that a nurse has met minimum professional standards and is competent to provide skilled, safe nursing care. States differ in both the minimum number of clinical practice hours and the number of required state-specific mandatory education classes or CEUs (Education Planet web page, 2000).

CAPT NC officers usually enter the Navy at the rank of ENS, but can be accessed as a Lieutenant Junior Grade (LTJG) or LT depending on prior work and educational experience. Most NC CAPTs are more senior than the other Corps and have completed between 20 to 30 years of service. Nurses have three distinct career tracks they can follow including executive medicine, nursing practice administration and education. Senior nurses can serve as department heads and Directors for Nursing Services (DNS) at mid to large size MTFs. All NC CAPTS are eligible for the command screening board. However, NC CAPTs with prior DNS experience have historically faired better at the command screening board.

The four corps just discussed makes up the target group when addressing the command screening process. The process impacts this group by the method in which it trains, mentors, places, and ultimately screens them. These are the individuals who seek out to be future leaders in Navy Medicine and the process is the gateway in which each member must pass in order to be a future executive and commanding officer.

2. Implementers

Quade (1989) defines the implementers as the individuals/organization that will actually carry out the policy decisions. Policies that affect our process flow are carried out, in most part, by several influencers at the Naval Personnel Command (NAVPERSCOM). These individuals include the Head, Medical Assignments/Placement Branch (PERS-4415), Head Dental Corps Assignments (PERS-4415G), Head, Medical Service Corps/Health Care Administration Assignments (PERS-4415I), Head, Medical Service Corps/Health Care Sciences Assignments (PERS-4415J), Head, Nurse Corps Assignments (PERS-4415K), and Head, Medical Placement (PERS-4415B). The individuals who work in the Medical Department assignment section are responsible for the proper distribution and career management of officers in the Navy Medical Department. As described in the process section, these individuals play a vital role in the Medical Department command screening board. They act as the member's advocate ensuring their record is ready and the member's intentions/career goals are properly communicated to the command screening board members.

These individuals report directly to the CNP and DCNP, but also report indirectly to the Navy SG and Corps Chiefs as to the distribution of Navy Medical Department personnel. These individuals carry out policies that directly affect the surveying of

eligible members, board preparation, board proceedings, and board selection notification. These individuals must be clear as to the policies affecting the board proceedings and selection process, and must be able to communicate these policies to the individual members.

The Special Assistant for Selection Board Matters (PERS-451F) also implements policy made by the CNP, DCNP and, indirectly, the Navy SG in his/her preparations for each command screening board. Proper procedures and guidelines must be followed to ensure fair and equitable board proceedings, ultimately leading to the "best qualified" members being selected. The Corps Chief's offices at BUMED also implement policy decisions that impact the command screening board. Each Corps Chief's office maintains a Career Planner position. This individual is responsible for providing career guidance to all members of the Corps, as well as drafting and publishing the career guidelines leading to executive management career paths. Three of the four Corps Chief's offices are directly involved in the command screening survey process and in preparing their respective Corps Chief for the board proceedings.

3.   Decision Makers

Quade (1989) defines the decision maker as the person who has primary responsibility for developing policy options and for recommending adoption of one option. The Navy SG is a three-star Medical Department flag officer who serves as both the Navy SG (special assistant to the Chief of Naval Operations (CNO)) and the Chief, BUMED (MED-00). As the Chief, BUMED, he is responsible for administering the overall policy and procedures for Navy MTFs and DTFs and Navy medical personnel located/assigned worldwide. He is also responsible for accomplishing the Navy Medical

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Department's mission of providing high quality, economical health care to the three million active duty and retired Navy and Marine Corps members, and their families (BUMED web page, 2000).

The Navy SG is selected from a one or two star Medical Department admiral and is appointed by the CNO to serve in this highly visible three-year assignment. The Navy SG will be promoted to vice admiral upon assuming the position. In 1996, the law was changed to permit any Medical Department officer (MC, DC, MSC, NC) to be eligible to serve as the SG in the three services (Army, Navy and Air Force). The standing SG serves as the President of the Medical Department command screening board. The SG also serves as the Head of the Council of Corps Chiefs, a formal committee, which includes the Chiefs of each Corps (MC, MSC, NC, DC).

The SG and the four Corps Chiefs make up the final deciding board, which screens individuals for command. The five individuals serve on the Navy Medicine's command screening board at NAVPERSCOM, and select individuals for command screening. Each of the five members has an equal vote for each record.

4.   **Influencers**

Quade (1989) defines influencers as people who are likely to have a direct influence on the policy decision because the decision-maker can rarely act by himself or herself. The decision maker must take into consideration the people that the policy impacts, the organization that will implement the policy decision and the influencers, who are there to protect the interests of the target group as well as remind the decision maker to work within the intent of current law and policies.

For the command screening process, the Corps Chiefs/Directors function in an influencer's and decision-maker's role. They serve in the role of influencer for their respective corps. These one and two-star flag officers serve in other official capacities while serving as Corps Chief/Director. For example, the current Chief of the MC is serving as the Deputy Surgeon General (DSG/MED-09), the current Director of the NC is serving as the Commander, National Naval Medical Center (NNMC), Bethesda, and the current Director, MSC is serving as the Navy Medicine Inspector General (IG). In his Corps-specific role, the Chief, Navy MC (MED-00MC) serves as the principal advisor to and advocate for all members of the MC; provides Chief, BUMED with centralized, coordinated advice on policy development to efficiently manage the MC; provides a corporate forum for addressing issues of concern to the Navy's physician constituency; and ensures all statutory and regulatory physician community management responsibilities are met (BUMED web page, 2000).

The Director, Navy DC (MED-00DC) develops, coordinates, evaluates, advises, monitors, and represents the Medical Department on policies, plans, and requirements affecting Navy dental officers. The Chief of the DC also assesses and provides policy guidance in the areas of procurement, selection, promotion, dental special pays, undergraduate and graduate dental education, use, distribution, assignment, career development, and disposition of Navy dental officers; acts as the Navy Medical Department spokesman, regarding all dental professional matters, to military and civilian counterparts; and performs all functions prescribed by law or regulation for the Chief of the DC (BUMED web page, 2000).

The Director, Navy MSC (MED-00MSC) provides centralized, coordinated policy development and guidance for MSC matters; develops, implements, and maintains MSC programs which support overall mission objectives and policies established by CNO and Chief, BUMED. The Director, Navy NC (MED-00NC) provides centralized, coordinated policy development and guidance for professional nursing matters in operational and conventional settings, and develops, implements, and maintains NC programs which support and sustain overall Navy Medicine mission objectives and policies established by the CNO and Chief, BUMED (BUMED web page, 2000).

CNP and DCNP must ensure that all formal boards (including the Medical Department command screening board) operate within the confines of the law and public policy. Although these particular individuals own the board process and could also be viewed as decision makers, we believe they act more as lobbyist to the SG because as Quade states, the decision maker must consult these lobbyists before a decision is made; and the lobbyists are involved in initiatives which require changes in the law. These individuals own the process and follow the law. Policy changes initiated by the SG must be approved and/or endorsed by these two individuals.

Another entity considered an influencer in the command screening process is ASD(HA). ASD(HA) is the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense and the Under Secretary of Defense for Personnel and Readiness for all DoD health policies, programs, and activities. ASD(HA) has the responsibility to effectively execute DoD's healthcare mission, that of providing and maintaining the readiness to provide healthcare services and support to members of the armed forces during military operations. ASD(HA)'s other healthcare mission is to

provide healthcare services and support to members of the armed forces, their dependents, and others entitled to DoD healthcare. In carrying out these responsibilities, ASD(HA) exercises authority, direction, and control over the medical personnel, facilities, programs, funding, and other resources within the DoD as well as establishes policies, procedures, and standards that govern DoD healthcare programs (ASD(HA) web page, 2000). ASD(HA) also provides guidance to the Lead Agents for each of the TRICARE regions around the world.

Congress is also considered an influencer, which has oversight of all Department of Navy (DoN) activities and resource expenditures. Both of these organizations provide recommendations and suggestions for outcomes from the command screening process. The outcome of the command screening process is COs and XOs who are held responsible for both active duty military health needs as well as all qualified military health beneficiaries.

G.   STRENGTHS, WEAKNESS, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS

This section identifies internal strengths and weaknesses of the command screening process along with external opportunities and threats. The analysis of these four elements, commonly referred to as a SWOT analysis, is useful in describing the internal and external conditions associated with the command screening process (Bryson, 1995). Data for the SWOT were obtained from interviews conducted with the Navy Surgeon General and Chiefs of the MC, DC, MSC, and NC. Figure 15 summaries the SWOT analysis.

Figure 15. Command Screening Process SWOT Summary

Strengths	Weaknesses
• Cooperative Relationships and good communication among board members • Well defined process including selection based on documented performance	• Fitness report inaccuracy • Target groups' understanding of the process • Marketing policies & changes • Time constraint
Opportunities	Threats
• Improve Communication - particularly by educating the target group (i.e, required competencies) • Improve Accuracy of Fitness Reports • Compare Best Practices of URL & Civilian Healthcare Selection Processes	• Political Interference • Organizational Mandates • Process Control • Loss of Continuity

1.   Strengths

As shown in Figure 15, respondents identified two common themes characterized as strengths of the current command screening process: *(1) cooperative relationships and good communication among board members and (2) well-defined process including selection based on documented performance.* The *cooperative relationships and good communication among board members* strength means the key process owners

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understand the command screening process and work well with one another. Navy Medicine has been granted a waiver to have repeat membership for this board. The waiver allowing for repeat members provides continuity among board membership. Since the board consists of the SG and the four Corps Chiefs, each of the four medical community perspectives is represented. The different personalities are viewed as synergistic and unified in terms of selecting best possible leaders for Navy Medicine. Additionally, each Corps Chiefs has a deputy who keeps the day-to-day operations flowing. The deputies perform a myriad of administrative and staff functions, which appear to positively contribute to good board relationships and effective communication. Good communication is also perceived to carry-over to how the Corps Chiefs work with implementers at the Naval Personnel Command. *Well-defined process including selection based on documented performance* is perceived as a strength. Each member of the board perceives the command screening process to be composed of a *well-defined set of procedural steps. Documented performance* is a strength associated with a well-defined process. It means individuals are selected based on best records. Records include fitness reports and accomplishment of a competencies checklist. The record evaluation provides a standard for screening. Since each board member has served as a MTF or DTF commander at least once in their career, it ensures a high level of practical experience on the board.

2. Weaknesses

There were four perceived weaknesses associated with the command screening process: *Fitness report inaccuracy, target groups' understanding of the process, marketing policies and changes, and time constraints. Fitness report inaccuracy* was the

most pressing weakness. According to the board members, fitness reports may not clearly document performance accomplishment and potential. Individual's strengths and weaknesses are not being clearly captured in some fitness reports. For example, the individual may be an outstanding clinician, financial expert, or service provider, but the fitness report may not adequately reflect fitness for CO/XO. *Target groups' understanding of the process* means that not all of the procedures are written down. Not having all the procedures written down generates confusion and subjective interpretation of some aspects of the sub-processes within the overall command screening process. *Marketing policies and changes* means that information regarding the process is a weakness in that apparently a fair amount of officers may not know or understand the process. Distributing information takes time and resources away from other operational requirements. *Time constraints* were a weakness because of operational overload. Multiple responsibilities constrain the amount of time available to devote to the process, including time for meetings.

3. Opportunities

Three opportunity themes emerged to improve the command screening process: *improve communications,* particularly by educating the target group (i.e., required competencies); *improve accuracy of fitness reports;* and *compare best practices of URL and civilian healthcare selection processes.* There are many benefits from capitalizing on the opportunity to improve communications, particularly in terms of educating junior officers (target group) on required competencies for CO/XO. Improving communications means officers have greater opportunities to plan their tours and align their jobs for desired CO/XO positions. The difficult problem of fitness report inaccuracies presents an

opportunity to refine and educate commanding officers on the value of clear and concise reporting, particularly regarding command potential. There was an expressed opportunity to compare best practices of URL and civilian healthcare communities. Examining alternative selection processes could result in improved criteria and cycle time reduction methods.

4. Threats

From the perspective of Navy Medicine leadership, there were four main threats to the command screening process: *political interference; process control; organizational mandates; and loss of continuity. Political interference* refers to excessive outside influence on the process, including selection based on personality instead of experience and capability. Put bluntly, the URL community could attempt to impose alternative mandates, structure, and selection criteria. New mandates could require BUMED to change its process, including the possibility of rotating board membership annually. The loss of continuity threat refers to disruption of what is perceived to be a united board membership. The SG and Council of Corps Chiefs have built positive relationships.

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VI. DATA ANALYSIS

A. INTRODUCTION

This chapter presents the results of data analysis used to describe and evaluate the Navy Medical Department command screening process. Results will be used to draw conclusions concerning the efficiency and effectiveness of the process in terms of selecting the "best qualified" candidates for command positions. Data is drawn from two primary sources: a written questionnaire obtained from current command screened personnel and personnel eligible to be screened for command positions, and interviews conducted with various stakeholders involved in the processes. One hundred forty-six returned questionnaires were used to evaluate perceptions and level of knowledge of the target stakeholder group.

Semi-formal interviews were conducted with five personnel referred to as decision makers. The purpose of the interviews was to gain additional insights about how Navy Medicine leadership makes selection decisions, communicates and educates target group members about the command screening process.

B. TARGET GROUP QUESTIONNAIRE

The purpose of the questionnaire was to assess the target group's knowledge and perceptions of the command screening process. The target group of the process consists of approximately 1,200 Navy Medical Department Captains (CAPTs) and Captain selects in each of the four Corps. A total of 146 questionnaires were collected representing approximately 12 percent of the target group.

The questionnaire was designed to take about 10 minutes. Likert-scaled questions and ranking type questions were used. The former allows quantitative analysis of responses including goodness of fit (chi-squared), and the latter forces prioritization of choices on some questions. Some redundant type questions were used to validate previous answers. Some demographic information was obtained. The final question was open–ended to obtain suggestions for improving the command screening process. The questionnaire took three weeks to administer. A copy of the survey can be viewed in Appendix A.

The intention of the demographical information was to analyze the following: specific corps, average years of service (YOS), gender, prior or current CO and prior or current XO when compared to the total target group. Results from the questionnaire are depicted in Figures 18 through 32, and Tables 3 through 5. Figure 16 provides the percentage representation for each of the corps. Table 2 displays the YOS for the total group as well as each of the six categories analyzed, including the gender percentage for each category.

Figure 16. Corps Representation in Percentages

Corps Representation

Medical Service Corps 24%

Medical Corps 26%

Dental Corps 25%

Nurse Corps 25%
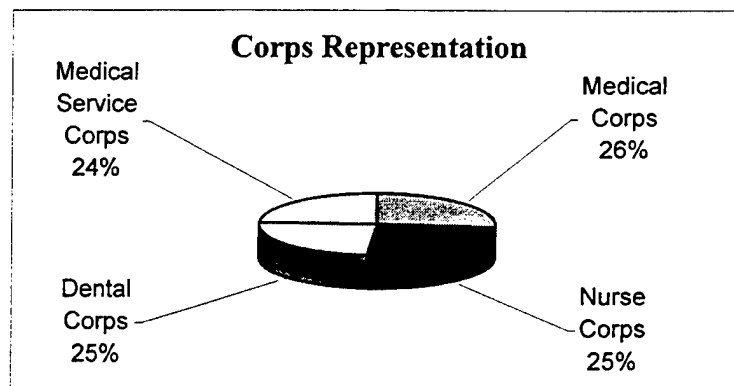
Table 2. Demographic Questionnaire Results

Category	Average YOS	Male %	Female %
All	23.7	69	31
MC	20.7	87	13
DC	22.2	89	11
MSC	26.4	80	20
NC	25.7	19	81
CO	27.5	74	26
XO	25.9	81	19

Twelve Likert-scaled questions were analyzed using a Chi-Square (χ^2) test of statistical significance. The χ^2 test determines if the responses to each question were random or whether something unrelated to chance was occurring. The χ^2 formula, displayed in Figure 17 refers to a Goodness-of-Fit Test. When the calculated value of χ^2 is equal to or greater than 3.84, the probability that the responses did not occur randomly is at least 95 percent, and if the calculated value of χ^2 is equal to or greater than 6.64, the probability that the responses did not occur randomly is at least 99 percent.

Figure 17. Formula for Goodness-of-Fit Test

$$\chi^2 = \frac{((M - m - 1)^2}{M + m}$$

M = Majority $\quad \chi^2 \geq 3.84, p \leq .05$

m = Minority $\quad \chi^2 \geq 6.64, p \leq .01$

p = probability of error

Question 1 has a χ^2 value of 18.14, p ≤ .01. This indicates that the target group

generally agrees that they are familiar with the Medical Department command screening

process. Their responses are statistical significant.

Figure 18. Question 1 Results
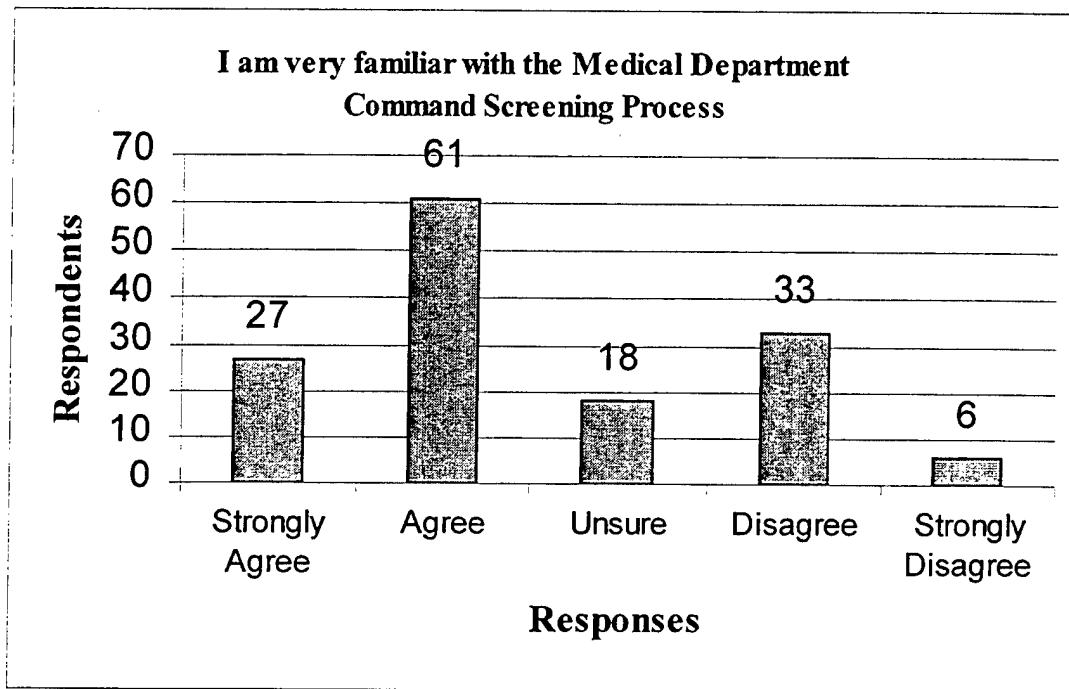
Question 2 indicates that the target group generally disagrees that they are

familiar with who serves on the command screening board. The χ^2 value of 6.39, p ≤ .05

is statistically significant, i.e. there responses are non-random.

Question 3 asked if the person who briefs the record is instrumental to an

individual's selection. The results presented in Figure 20 show nearly half of the

respondents neither agreed nor disagreed with this statement, but of the half that agreed

or disagreed, the over whelming response was agreed. The χ^2 value of 31.65, p ≤ .01 is

statistically significant that this group believes that the briefer of the record is instrumental in terms of selection. The relatively large number of unsure responses may indicate either a poorly worded question or low knowledge of the question content.

Figure 19. Question 2 Results

I know which medical department officers serve on the Command Screening Board

Bar chart — x-axis "Responses", y-axis "Respondents":
- Strongly Agree: 15
- Agree: 28
- Unsure: 30
- Disagree: 43
- Strongly Disagree: 28
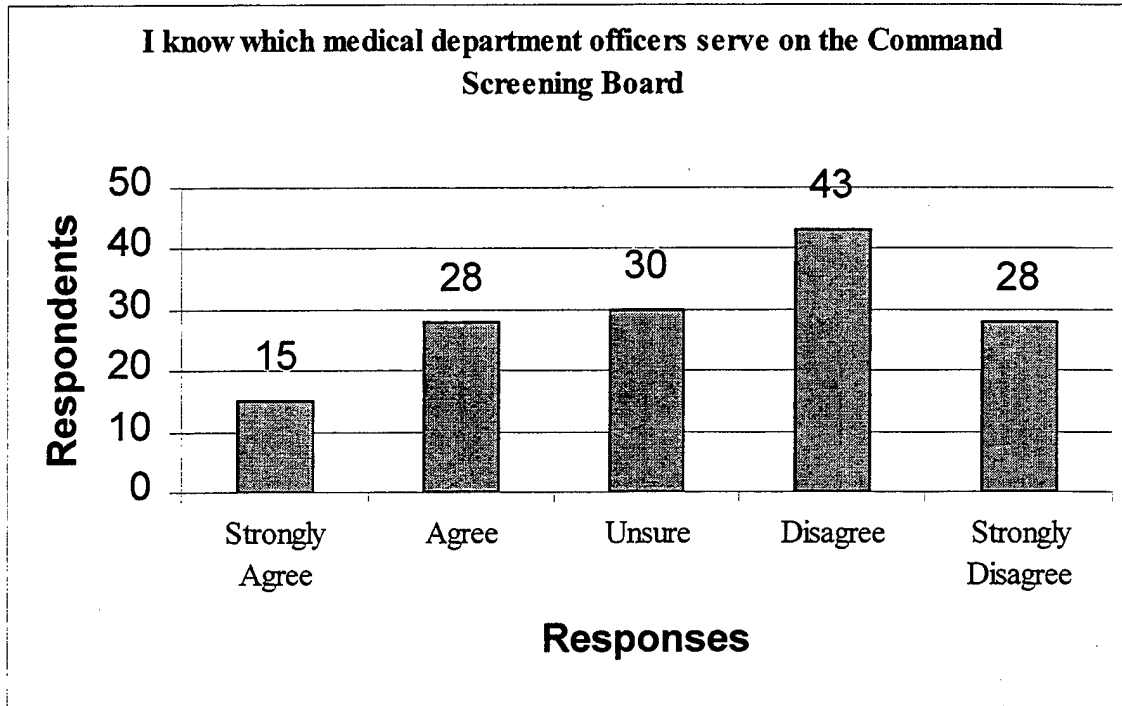
Figure 20. Question 3 Results

The person who briefs the record during the Command Screening Board is instrumental to an individuals selection
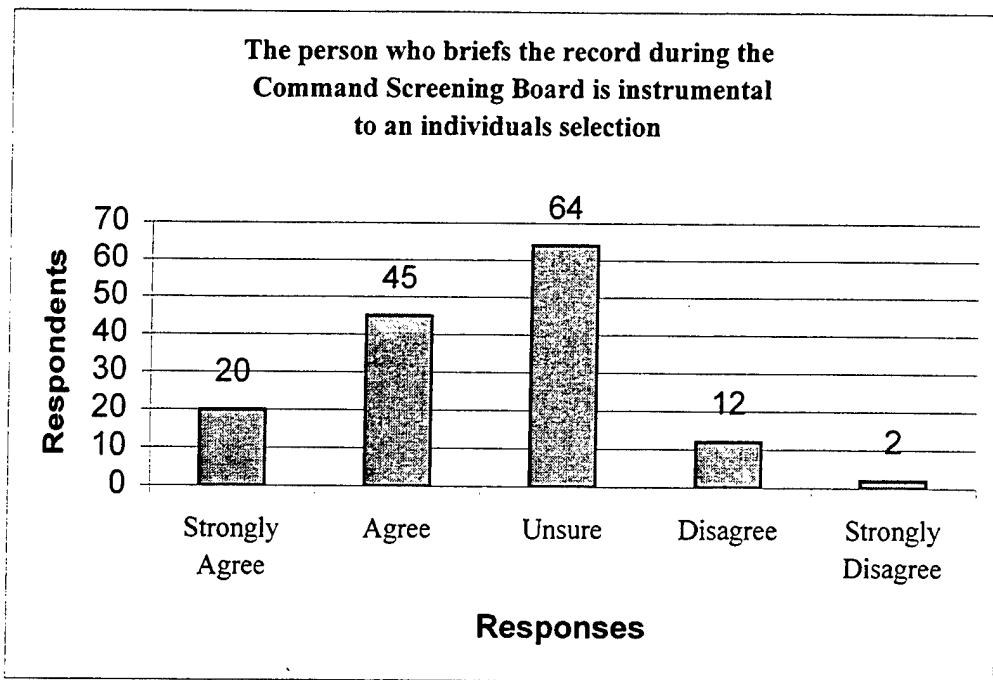
Figure 21. Question 5 Results

The screening process is objective
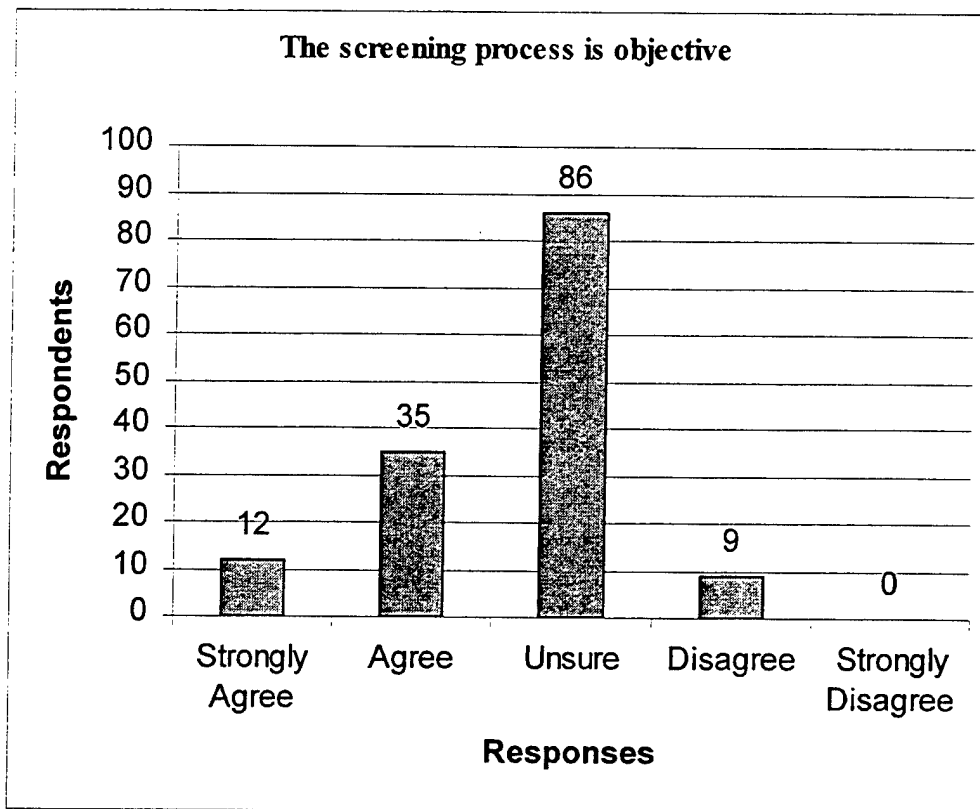
Question 5 asked respondents if the screening process is objective. Similar to Question 3, many respondents entered the answer of unsure equating to 60 percent of the total responses. However, of the respondents who either agreed or disagreed, the χ^2 value of 22.45, $p \leq .01$ is statistically significant, indicating that the target group in general, agrees that the screening process is objective. The large number of unsure responses may indicate a substantial level of uncertainty concerning perceived objectivity of the process.

Figure 22. Question 6 Results
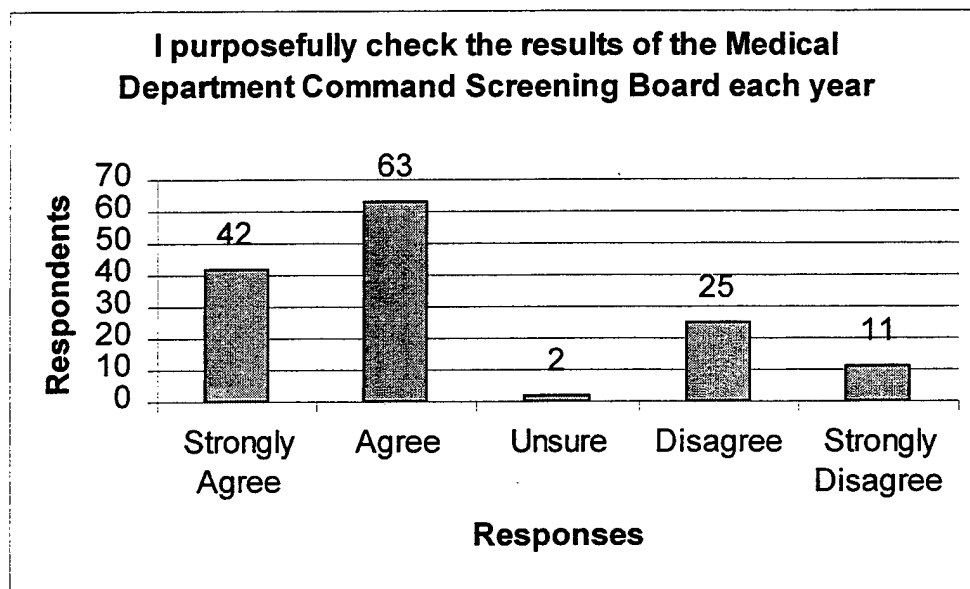
Responses to Question 6 indicate that the target group purposefully checks the results of the Medical Department screening board each year. The χ^2 value of 32.79, $p \leq .01$ is statistically significant. This question seeks to determine if respondents are personally involved in checking annual screening results.

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Question 8 reinforces questions 1 and 2 by testing respondent's knowledge of the

screening process and assignment process for command. The question asked if

individuals selected for command screening were also selected for CO/XO assignment at

the same time. Over 82 percent of the respondents provided the correct answer, i.e.

processes are not simultaneous. An individual could be on a screened list for several

years before taking command or a person may never take command even though they

have been screened. The χ^2 value of 100.99, p ≤ .01 is statistically significant indicating

systematic responses to the question. Results can be seen in Figure 23.

Figure 23. Question 8 Results

Individuals selected for Command Screening are selected for CO/XO assignments at the same time
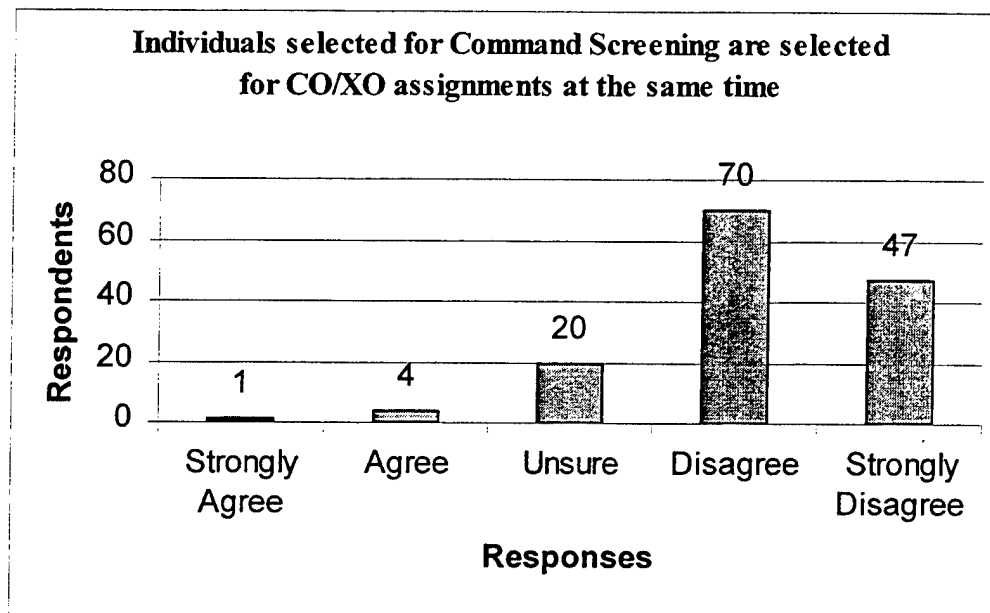
Figure 24. Question 9 Results

Medical Department officers should be given the option of voluntarily withdrawing their name from the Command Screening Board
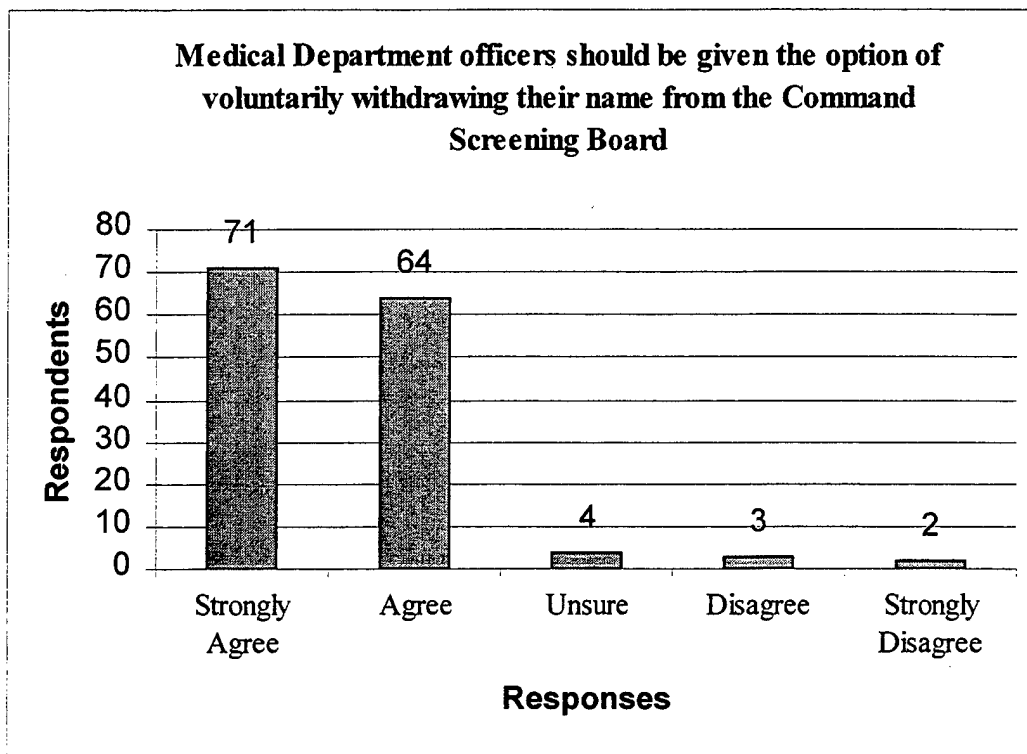
Question 9 had the largest amount of agree responses from the questionnaire. The question asks if "Medical Department officers should be given the option of voluntary withdrawing their name from the command screening process." Results depicted in Figure 24 show over 93 percent of the respondents agreed or strongly agreed with this option. The χ^2 value of 118.86, $p \leq .01$ is statistically significant.

In Question 10, the respondents were asked if the command screening process differentiates between an executive medicine career versus a clinical medicine career. Results in Figure 25 show the target group agrees, the process differentiates between the two career paths. The χ^2 value of 9.23, $p \leq .01$ is statistically significant.

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Figure 25. Question 10 Results

The Command Screening process differentiates
between an executive medicine career versus a clinical
medical career
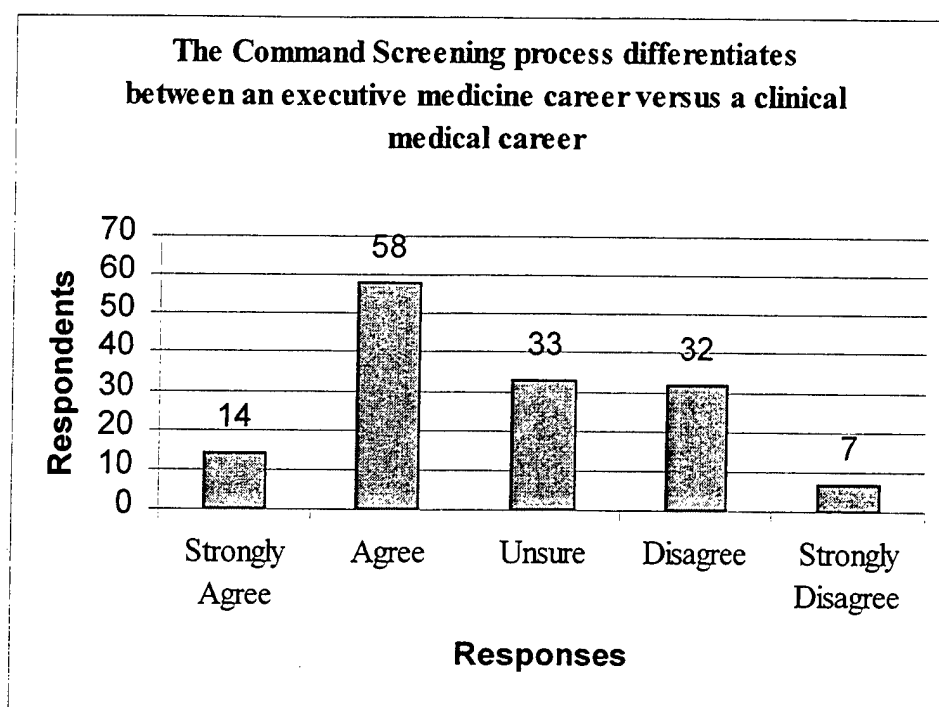
Figure 26. Question 11 Results

I am very involved in my
executive medicine career path
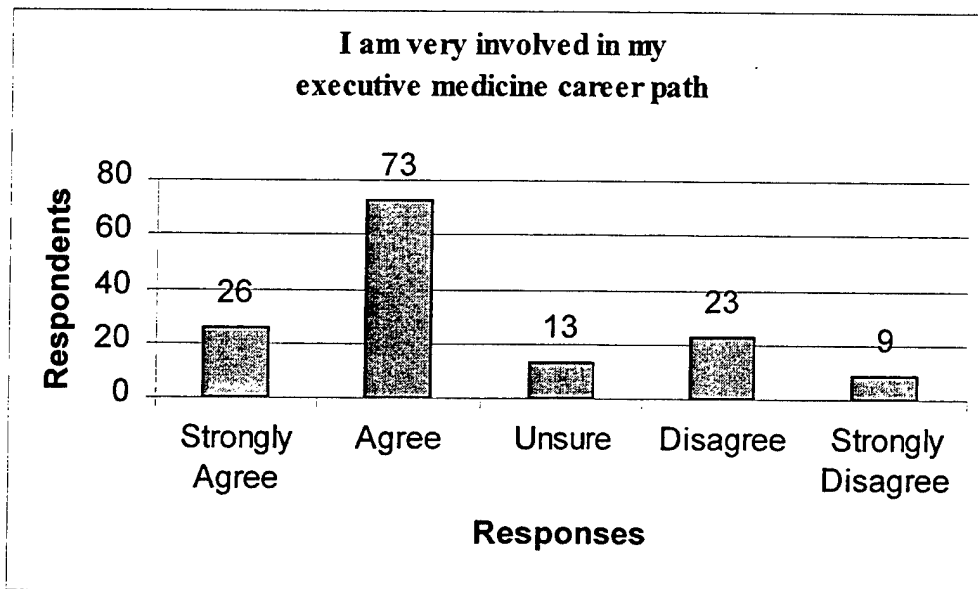
Question 11 asked if respondents are very involved with their executive medicine

career path yielded a 68 percent response rate in the affirmative. The χ^2 value of 33.25,

p ≤ .01 is statistically significant. This question is based on individual preference regarding career goals. The question was to determine if the group in the aggregate took an active role in their executive medicine career path, and they said they did.

In Question 12, the target group was asked if selection for CO/XO screening is career enhancing. Figure 27 shows almost 80 percent of the respondents believe that screening for CO/XO is career enhancing. The χ^2 value of 75.88, p ≤ .01 is statistically significant.

Figure 27. Question 12 Results
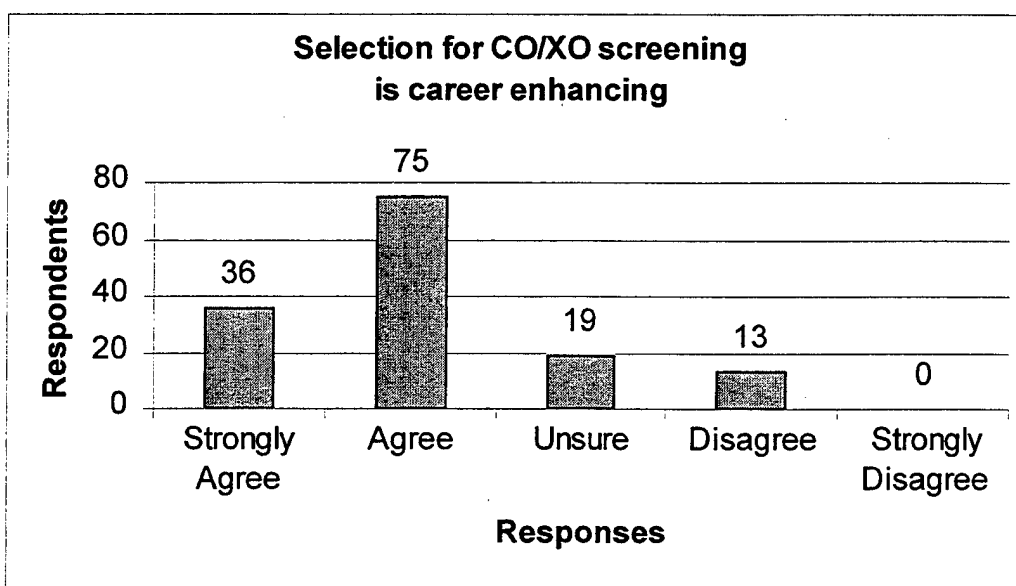
Question 16 asked respondents if they think Navy Medicine effectively prepares junior officers for future assignments as CO/XOs. In a two-to-one margin (85 to 42), as shown in Figure 28, respondents perceive that Navy Medicine does not effectively prepare their junior officers for future assignments as CO/XOs. The χ^2 value of 13.09, p ≤ .01 is statistically significant.

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Figure 28. Question 16 Results

Navy Medicine effectively prepares junior officers for
future assignments as COs/XOs
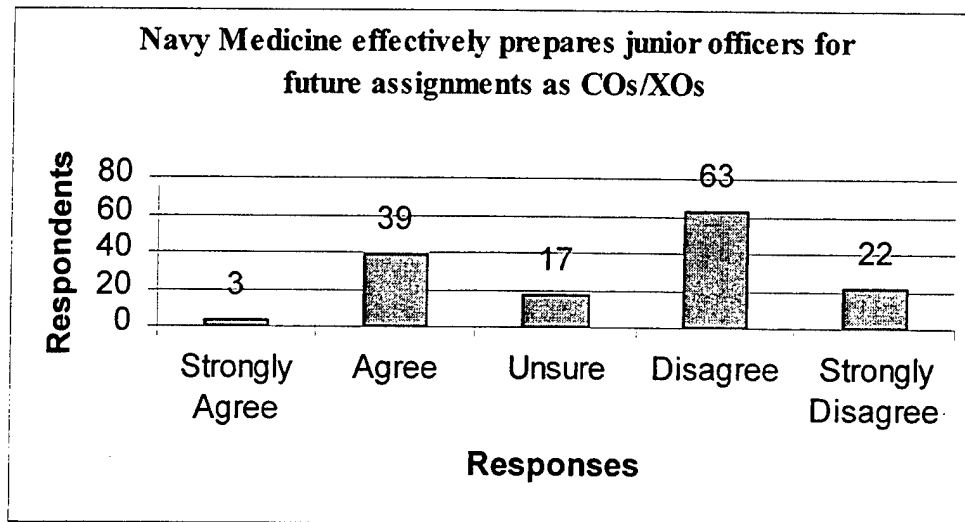
Question 18 asked the target group if "The command screening process is fair?"
Although many respondents were unsure (68 of 141), a significant number perceived the
process to be fair ($\chi^2 = 52.66$, $p \leq .01$). Less than four percent perceived the command
screening process to be unfair. See Figure 29. The relatively large number of unsure
responses would be a good area for follow-on analysis outside the scope of this study.

Figure 29. Question 18 Results

The Command Screening Process is Fair

Response	Respondents
Strongly Agree	9
Agree	59
Unsure	68
Disagree	5
Strongly Disagree	0
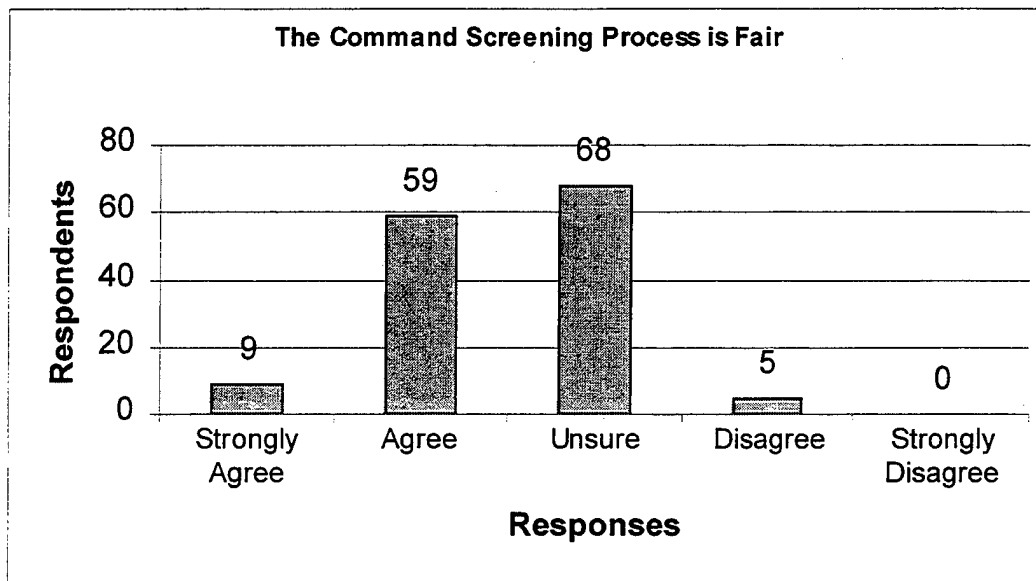
Questions 4 and 7 asked for specific knowledge answers regarding the command screening process. Question 4 asked respondents to choose from a list of who (position) briefs their record at the command screening board. The choices included: Surgeon General, Career Planner, Specialty Leader, Corps Chief, Detailer, Current or prior COs/XOs, Other Captains and Unsure. Figure 30 displays the top three answers and combines the five lowest responses into the category of all other responses. The largest response was unsure by almost a three-to-one margin (93 to 37). The second highest selection was Corps Chief, and the third was Detailer. The unsure response captured almost 60 percent of the target group's answers. If the question was understood then many respondents were either unsure (60 percent), or missed the correct answer (15 percent). Twenty-five percent answered correctly, i.e. Corps Chief.

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Figure 30. Question 4 Results

Who briefs your record at the command screening board
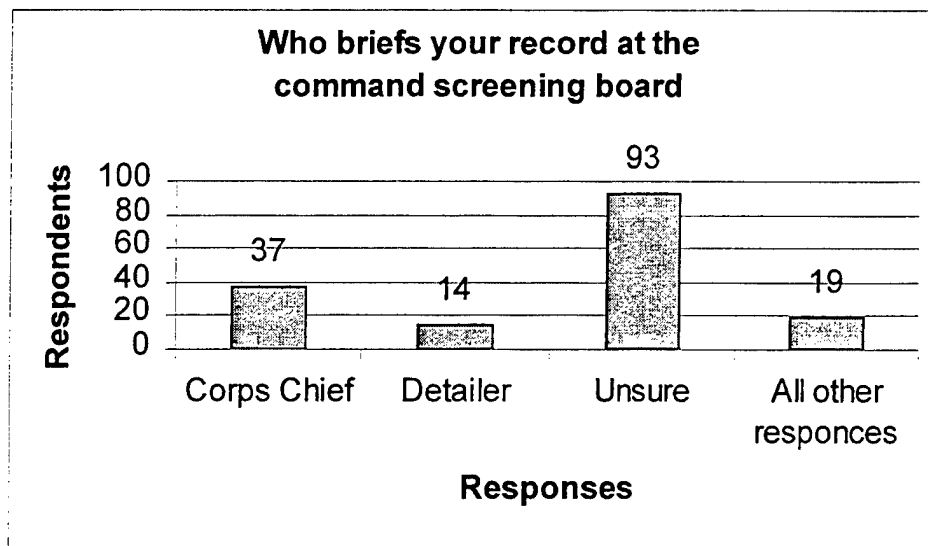
Question 7 asked, "Once screened, how long does an individual remain on the Command Screened list?" This is a knowledge question and a way to proximate if changes to the process are communicated to the target group. Currently, once someone screens for command they are on the screened list indefinitely, unless they are administratively removed due to pending retirement, declining work performance, or some other personal reason. Figure 31, shows the two major groups of responses: three years and indefinite. Three years reflect a policy that has subsequently been changed to indefinite.

Figure 31. Question 7 Results
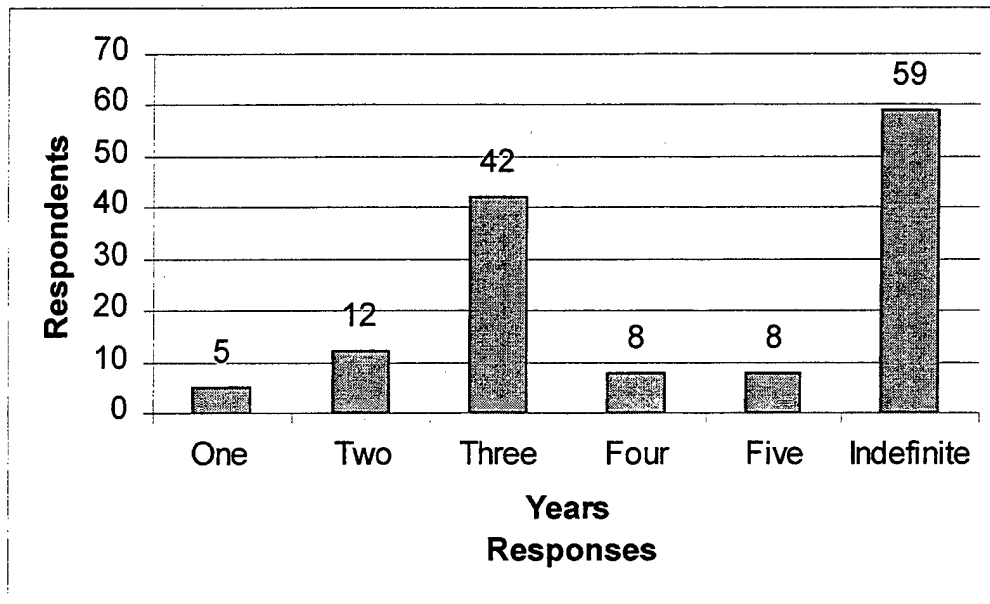
Questions 13, 14, and 15 involve ranking top three selections from a list of possible answers. Question 13 asked respondent to "Rank the top three reasons you would seek selection for CO/XO positions" from the following alternatives: (1 = top selection, 2 = middle, 3 = third choice)

- Personal Satisfaction
- Career Accomplishment / Milestone

- Greater Responsibility
- New Experience

- Improve Navy Medicine
- Prepare for Civilian Job

- I Earned it
- Not Applicable

Table 3 shows arithmetic modes (bold) depicting respondents top three reasons for seeking CO/XO positions.

The largest category selected for seeking CO/XO positions was to "Improve Navy Medicine." This choice captured 43 percent of the total responses and reflected a two-to-

one ratio (68 to 28) over the next higher choice. The second and third rankings were

"Greater Responsibility, and Personal Satisfaction."

Table 3. Question 13 Results

Question 13	RANKING			Total selected for this category
CHOICES FOR SEEKING SELECTION	1	2	3	
Improve Navy Medicine	**60**	26	9	**95**
Greater Responsibility	17	**36**	**27**	**80**
Personal Satisfaction	28	27	22	**77**
I Earned it	0	0	1	1
Career Accomplish/Milestone	19	24	25	68
New Experience	11	15	21	47
Prepare for Civilian Job	3	0	5	8

Question 14 asked respondents to "Rank the top three reasons you think individuals are typically selected at the CO/XO Screening Board" from the following alternatives:

- Performance
- Education Level
- Politics
- Service Reputation
- Corps Affiliation
- Experience
- Variety of Assignments
- Unsure
- Prior/Current COs / Supervisors

Table 4 shows arithmetic modes (bold) depicting respondents top three reasons why they think individuals are selected at the CO/XO screening board. The number one response to why an individual is selected at the CO/XO screening board was "Performance" (50

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percent of the response rate on number one choice). The next two highest rankings were "Experience," and "Service Reputation."

Table 4. Question 14 Results

Question 14	RANKING			Total selected for this category
CHOICES FOR BEING SELECTED	1	2	3	
Performance	76	14	17	107
Experience	16	42	40	98
Service Reputation	22	32	30	84
Variety of Assignments	4	23	23	50
Education Level	3	3	5	11
Politics	18	16	10	44
Corps Affiliation	5	5	3	13
Prior/Current CO's/Supervisors	7	4	7	18

Questions 13 and 14 were compared in terms of two stakeholder groups' perceptions: (1) the decision makers (SG and Corps Chiefs), and (2) the target group (Captains in all the different corps). The decision makers ranked why they thought the target group would seek selection, and their responses were compared to target group responses. The ranking responses between the different stakeholders were identical or nearly identical. In Question 13, the number one choice by all the target group respondents was to Improve Navy Medicine. This was also the response of three decision makers. Two Corp Chiefs selected "Greater Responsibility." The second and third choices by all respondents were "Greater Responsibility," "Personal Satisfaction," and "Career Accomplishment/Milestone." In Question 14, "Performance" was unanimously selected by both stakeholder groups as the number one reason for an

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individual to be selected at the CO/XO screening board. The second and third choices were split between "Experience," "Service Reputation," and "Variety of Assignments."

Question 15 asked for the respondent to "Rank (1, 2, 3) the three most influential stakeholders in the Medical Department command screening process (1=most important) the choices were:

- Surgeon General   - Prior/Current COs

- Corps Chief   - Placement Officer

- Specialty Leader   - Individual Member

- Detailer   - Unsure

Table 5 shows arithmetic modes in bold depicting how respondents ranked the three most influential stakeholders on the CO/XO screening board. The target group ranked the Surgeon General as the most influential stakeholder with a total of 60 number one rankings, equaling 42 percent of the choices for the ranking category of one. The second highest ranking was the Corps Chief, followed by the Detailer. The total of all three rankings received over 70 percent of the choices from the respondents.

Table 5. Question 15 Results

Question 15	RANKING			Total selected for this category
CHOICES FOR MOST INFLUENTIAL STAKEHOLDERS	1	2	3	
Surgeon General	**60**	22	22	**104**
Corps Chief	49	**67**	6	**122**
Detailer	5	11	**39**	**55**
Specialty Leader	0	4	10	14
Prior/Current COs	5	12	24	41
Placement Officer	1	5	2	8
Individual Member	19	6	19	44

Question 17 asked, "At which grade should Navy Medicine identify potential future COs/XOs for Medical/Dental Treatment Facilities?" Respondents were to pick one of four ranks: Lieutenant (03), Lieutenant Commander (04), Commander (05), or Captain (06). The selection of Captain (06) would indicate no change to identifying potential future CO/XOs. The question is a follow-on question from Question 16, which was asking if the Navy Medicine effectively prepares junior officers for future assignments as CO/XOs. Question 16 was statistically significant that the target group thought Navy Medicine does not effectively prepare junior officers.

The goal of Question 17 was to obtain input on what rank respondents perceive individuals should be identified. The aggregate answer was Commander (05). The rank of Commander was selected for 45 percent of the responses. The rank of Lieutenant Commander (04) was the second selection with 40 percent. Captain (06) received nine percent and Lieutenant (03) six percent. See Figure 32.

When comparing the aggregate results to the comparison groups, two groups had higher percentages of respondents in the rank of Lieutenant Commander (04). The two groups were prior/current COs and the Nurse Corps with 48 and 56 percent respectively for the rank of Lieutenant Commander (04). The remaining four groups selected the rank of Commander (05) as the highest percentage of responses for identifying future potential executive leadership.

Figure 32. Question 17 Results
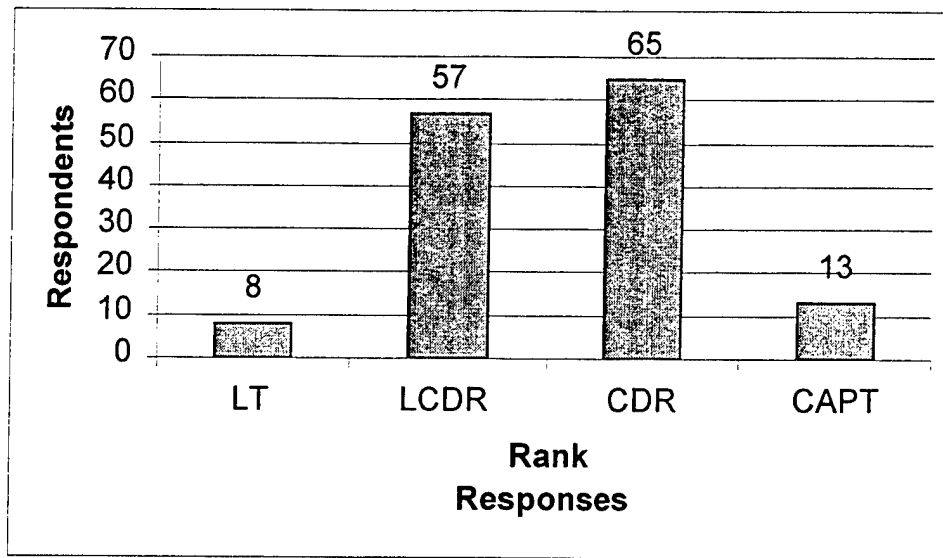
Question 19 was an open-ended question seeking suggestions for improvement to the Medical Department command screening process. Approximately 46 percent (68 of 146) of the respondents provided written inputs. Four main themes emerged. Five or more similar responses were considered a theme. The most mentioned theme was "process clarification." Seventeen respondents wanted a plain explanation of the process, i.e., demystify how the process occurs by letting individuals know what helps prepare them for CO/XO, and what factors the board considers.

The next most common theme was requesting more "marketing and education of the process" (13 responses). Similar to process clarification, respondents were suggesting ways to educate officers and methods of publicizing the process. Recommendations included getting the rules down on paper, promulgating a formal instruction, and providing advantages and disadvantages of executive medicine screening. The third common theme was for a better "defined career path," i.e., knowing

the types of positions to serve in, and developing the needed skills and talents required for successful CO/XO screening. Some respondents requested clarification on a career path and preparation requirements for command. The last theme was for individuals to "screen earlier." Similar to results of Questions 16 and 17 in the questionnaire, respondents were suggesting screening individuals at Commander and serving as an XO at the rank of Commander. Some respondents recommended identifying individuals earlier who have command potential and placing them in a preparatory billet for the XO positions.

C.   STAKEHOLDER INTERVIEWS

A complete list of key stakeholder interview questions is provided in Appendix C. The Surgeon General (SG) and the four Corps Chiefs were the five key stakeholders identified as the decision makers in this study. They are all members of the Council of Corps Chiefs. The SG is the individual responsible for administering the overall policy and procedures for Navy MTFs and DTFs. Each Corps Chief is an advocate for their respective Corps. To facilitate understanding of the data presented below, the topic or question is provided at the beginning of the subsection, followed by a synopsis of the stakeholders' response. Responses that were common to all or several of the stakeholders are presented first, followed by specific perspectives. No names are reflected in this thesis.

These stakeholders have diverse functions but one common mission and responsibility. The command screening process will be the focus of the questions and what role each key stakeholder has in the process. The output of this process provides a

pool of professionally qualified executive medicine leaders. This pool is used to select the next CO/XO of MTFs and DTFs.

Question 1: "How important is the Navy Medicine command screening process on a scale from one to ten (ten being most important)." Without hesitation, all five individuals ranked the Medical Department command screening process a ten. They said that picking the future leaders in the MTFs and DTFs is critical to the success of delivering health care. They stated that the future leaders have to formulate the vision and motivate people.

Question 2: "Do you think screening for CO/XO was career enhancing?" The answer was yes. The group viewed accepting a CO/XO position takes individuals to a whole new level of managing medicine and dentistry. The expanded responsibility from the position allow for further development of professional business skills.

Question 3: "How is the command screening process tied into Navy Medicine's Strategic Plan?" All five stakeholders referred to the People pillar of Navy Medicine's strategic plan, which also states goals of developing Navy Medicine leaders. The goal is tied with putting the right people in the right places.

Question 4: "What kind of turnover did you get on the command screening process from your predecessor?" There was a general consensus that they were all familiar with the process and format prior to taking their positions. The turnover itself ranged from sitting on the board two times prior to becoming the Corps Chief to no turnover at all for three of the individuals.

Question 5: "How are policy changes/decisions made regarding this process?" All respondents noted that many decisions are made at the Council of Corps

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Chiefs meetings held on a monthly basis. This was stated as the appropriate place for decisions to be made and policies to change. There was an understanding from the four Corps Chiefs that ultimately the Surgeon General is the final decision maker.

Question 6: "Are you a decision maker or influencer and where does the Council of Corps Chiefs fall into the grouping of people?" The four Corps Chiefs all stated that they were both decision makers and influencers. The shared thought that their role on the Council of Corps Chiefs placed them in an influencer role and decision maker when it dealt directly with their specific corps. The Surgeon General claimed to be a decision maker and that the Council of Corps Chiefs is an influencing body.

Question 7: "What are your roles and responsibilities in the process to your corps, to Navy Medicine, as a member of the Council of Corps Chiefs?" All four Corps Chiefs stated that they are the main advocates for their corps, but Navy Medicine's needs come first, even if it does not benefit their particular corps. Occasionally the Corps Chiefs will advocate for another corps to be in a particular position if it is in the best interest of Navy Medicine. The SG stated he serves as a corps-less individual and his role is selecting future leaders. The SG stated, "I kind of keep the Corps Chiefs in the middle of the road serving as coach."

Question 8: "During our research, we found very little written information about the board process and policies. Why?" All stakeholders interviewed sited flexibility with the process and the ability to change it. Comments were made that if there is an instruction or written policy it could hamper the screening process.

Question 9: "Once screened, how long does an individual remain on the command screened list?" The goal of this question is to clarify a current

misunderstanding among the researchers and the target group with the length of time an individual remains on the screened list. All interviewees answered that the process has changed from a set period of time to indefinite period as long as you qualify to be screened. Their reason for this policy is added flexibility. Screened individuals may have limitations; geographic placement; exceptional family member issues, change their mind to serve as either CO/XO; etc. The larger screened pool provides the Council of Corps Chiefs the flexibility to select a better match with individual skills, preferences and personality compatibility for the front office.

Question 10: "Will everyone who is screened get either a CO/XO position?" The answer from all the stakeholders was no and this is due to timing, incompatibility match, administratively removed, and the fact that they screen more individuals than positions.

Question 11: "Does it hurt your career not to be screened?" All stakeholders stated that it does not hurt your career. The target group can continue serving Navy Medicine in their current role. They commented that in the medical field there are several different professions and unique skills required and not everyone will posses the skills needed to serve as a CO/XO.

Question 12: "Before the formal screening board was instituted in/about 1989, what was the process for selecting CO/XOs?" Three of the five did not know of the process in the mid 1980s. The SG stated it was mostly a "backroom affair...individuals selected were not clear on how the precept worked and the people who were selected were never sure how the process worked." The DC Chief recalled that

the detailer would call and ask if they were interested in being an XO and then the individual would have to obtain a recommendation from their current CO/XO.

Question 13: "How much time (in percentage) do you spend on the Command Screening process (survey distribution, board preparation, approving slates, ect.) per month?" The SG estimated between 5 and 10 percent. The MC, MSC, and NC Chiefs estimated somewhere in the 5 percent range. The DC Chief uses his quarterly video-teleconferences (VTC) to cover command-screening issues, as such, estimated 20 percent of his time.

Question 14: "How does Navy experience/years of service impact the selection process (CAPTs range from 16 years for MC and DC to 22 years of service for MSC and NC)?" The most common reply was that they were looking for future leaders with a common set of talents. Additional years of service are good, but they stated that you could not discredit the experience that is taken by individuals with less years of service. The Dental Corps path is different since all the COs/XOs are in the same community. The DC Chief stated that you follow a certain path and everyone must have completed a set career path prior to serving as an XO. The path to command for the DC is to serve as a department head, then clinic director of a small clinic, director of a larger clinic then, if you qualify, you may serve as an XO.

Question 15: "From our research, we learned that Navy Medicine command screening board is the only board held at the Naval Personnel Command that, by SECNAV approval, can use the same members each year. Why?" The group as a whole thinks that the Corps Chiefs know their community better than anyone else and tend to understand the diverse background that each individual corps comes from. They

all believe the process is fair and repeat membership to the board provides strength to the process.

Question 16: "How is the command screening process and changes to the process communicated to the target group?" The SG depended on the Corps Chiefs to get the word out, to communicate down through their corps. The SG stated that he covered the process in his monthly message to Navy Medical Department personnel. A majority of the interviewees placed information on their web sites or the Naval Personnel Command homepage. The DC Chief also has weekly dental up-dates published via web to convey any changes to the process. The DC Chief also has quarterly VTCs with all the Dental CO/XOs where this type of information is distributed as well. The MSC Chief stated that there is no media that goes out to everyone to inform them of how the process works and the changes from the prior year. The NC Chief believed that communicating this process to the target group was one area for improvement. Unwritten changes to the process create confusion among the target group.

Question 17: "From our research, we found that some of the CAPTs say there is not enough information available about the process. How do you view the effectiveness of the current communication regarding the process?" All stakeholders were surprised that individuals did not know the process. Some interviewees felt that if an individual was interested in specific parts of the process they could call the Corps Chiefs' office to obtain detailed information. One Corps Chief believed communications could be improved.

Question 18: "Another thing we have been finding is that many CAPTs think Navy Medicine should be identifying potential CO/XOs sooner in their career, specifically at the Commander level, similar to other Navy line and staff communities. Agree/Disagree?" Three of the five members agreed that screening individuals earlier is a good idea. Two Corps Chiefs felt that professional development occupied a majority of individual's time. Screening them earlier would deter from the current demand of the professional skills needed for patient care.

Question 19: "How do you know and/or measure if you selected the "best qualified?" Four of the five interviewees look at proven performance, demonstrated potential, leadership ability, range of experience, and understanding of how MTFs operate. These characteristics show up in the FITREP. The DC Chief measures the selection on prerequisite training, good clinical skills, experience as a department head and director, plus has a recommendation for command from their current CO/XO.

Question 20: "What do you foresee as future changes to the process/policies/marketing?" Three of the five interviewees stated future changes would move towards creating objective measures, a quantitative scoring method to measure individuals' performance, increase emphasis on the 40 competencies, and producing guidelines to better define the process. A comment was made that it depends on future leadership. Leadership is the real driver of the process, however, if you have a process that is well defined, it does not matter how often your leadership turns over.

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VII. CONCLUSIONS AND RECOMMENDATIONS

The Navy Medical Department's formal command screening process is only eleven years old. This study described the process and evaluated stakeholder's knowledge and perceptions. Organizational and policy models were used to explain aspects of the process. For example, the early process reflected elite decision-making, including incremental and bureaucratic-political model characteristics.

The following sections summarize conclusions and recommendations based on results of the study. Conclusions are drawn from the data presented and analyzed in Chapters IV, V and VI. Recommendations are offered to assist stakeholders in ways to continually assess and improve this important process for selecting the future leaders of Navy Medicine. The following conclusions and recommendations are based on relevant literature, a written questionnaire obtained from 146 target group Captains, and 21 semi-structured interviews conducted with Executive Navy Medicine stakeholders.

A. CONCLUSIONS

1. The Navy Medical Department command screening process is deemed important to executive senior leadership.

Navy Medicine's senior executive leadership consistently articulated that command screening is one of the most important processes within the organization. Selecting future leaders of MTFs and DTFs is crucial to the growth and success of Navy Medicine. Effective leadership is increasingly critical for making choices in the healthcare system under conditions of ambiguity and uncertainty. In summary, current leadership indicated that the command screening process is instrumental and important to

Navy Medicine and its stakeholders, including the readiness of all Navy personnel, Congress, and the citizenry.

2.   Overall, the command screening process is efficient and effective.

The desired output of selecting the "best qualified" candidate is generally achieved using minimal resources. Standardized processes, and primarily incremental changes, appear efficient. The overall process shows signs of being adaptive to environmental changes, i.e., military downsizing, the implementation of TRICARE, and shifting control of Navy Medicine's financial and personnel resources from line Navy to the Assistant Secretary of Defense for Health Affairs.

3.   The command screening process is directly linked to Navy Medicine's Strategic Plan.

Under the "People" pillar of Navy Medicine's strategic plan, one of the main goals is to enhance job satisfaction and career development. Job satisfaction means officers of different ranks choose to remain in Navy Medicine, and career development means individual and organizational goals are aligned to ensure the best officers migrate to command positions. Results of the interviews and comparison with the strategic plan show that these concepts have been purposefully linked in order to encourage and stimulate the development of future leaders.

4.   The command screening process meets the unique needs of Navy Medicine.

The process fits Navy Medicine's highly professional organizational structure. Medical Department officers come from one of four diverse corps (MC, DC, MSC, and NC); all with different educational backgrounds and career paths. Maintaining a large pool of screened candidates (some who may never receive a command assignment),

holding a formal screening/selection board, allowing senior officers to remain in a clinical career path and decline command, and repeat board membership are meaningful differences in the Medical Department's command screening process compared to other Navy line and staff communities. Navy Medicine's command screening process accommodates many of the institutional unique needs.

5.   The "best records" are selected at the command screening board.

Formal command screening boards are administrative boards, and as such, are conducted in the same manner as statutory promotion selection boards. Assignment officers at NAVPERSCOM, Corps Chief's/Director's staff, as well as members of the formal command screening board review service records as part of the command screening process. Results indicate that selection is predominantly based on "best records."

6.   Relationships between decision makers and implementers are interdependent and focused, i.e. screen the "best qualified" candidates.

Interview results indicated effective working relationships between the Navy Surgeon General and Corps Chiefs/Directors (decision makers) and medical assignment/placement officers located at the Naval Personnel Command and Corps Chief/Directors office staff (implementers) located at BUMED. Members in both groups expressed that no one group can accomplish this important and far-reaching task. In short, relationships must be interdependent to be effective. Additionally, the overriding goal of screening and selecting the "best qualified" candidates for CO/XO provides needed focus. Implementers make preparation for the board, and collecting and

evaluating command screening surveys from the target group. Decision makers use this information to make final selections.

7. Self-exemption from command screening is deemed acceptable and fits the unique professional structure of Navy Medicine.

Navy Medicine CAPTs strongly believe that officers should be given the option of voluntarily withdrawing their name from the command screening process, i.e., self exemption makes sense. Health care professionals often spend many years learning their occupation and continuously upgrading their skills by attending conferences, peer group meetings, and retraining to become more specialized. It is not unusual for someone with a narrowly specialized level of expertise to want to remain specialized and not enter into executive medicine. Medical Department officers on average, defend the self-exemption concept because it is aligned with the reality of specialized professionalism in clinical medicine.

8. Two factors provide needed flexibility to senior executive leadership: unwritten directives, and maintaining a large pool of screened CO/XO candidates.

This conclusion refers to the substantial reliance on oral interpretation of the screening and selection process on the part of key Navy Medicine leaders. Basically, senior leaders indicate that to the extent that policies are amenable to verbal interpretation, needed flexibility is obtained.

Similarly, maintaining a relatively large pool of screened CO/XO candidates provides needed flexibility, particularly in terms of matching individual candidates with diverse command leadership positions. Navy Medicine maintains a large list of screened CO/XO candidates in order to provide the assignment officers and senior decision makers

with flexibility during the identification and selection phase of the command screening process. PRDs, job matching and Navy Medicine command-specific assignment policies provide unique challenges in getting the right person in the right place at the right time.

9.   The command screening process compensates for differences in years of service among Medical Department Captains.

Depending on Corps affiliation, Medical Department officers enter the Navy at different ranks and are eligible for command screening at varying years of service. MC and DC officers usually achieve the rank of CAPT at their 16th year of service, while MSC and NC officers achieve the rank of CAPT at their 20th year of service. This disparity is compensated for during the command screening process. The Surgeon General and Corps Chiefs/Directors look for a common set of talents/competencies when selecting the "best qualified" officers into the command screened pool. CAPTs with less total years of service must have demonstrated the same leadership potential as CAPTs with more total years of service, i.e., no penalty based on less years of service. Civilian leadership experience prior to entering the Navy is also taken into consideration for command selection.

10.   Medical Department Captains, on average, seek command for similar reasons.

Based on the target group survey results, the top three reasons (in order), why Navy Medical Department CAPTs seek command are: improve Navy Medicine, greater responsibility, and personal satisfaction. When asked the same question during the semi-structured interviews, the Surgeon General and Corps Chiefs/Directors had similar responses. The responses also coincide with the three major reasons why civilian healthcare executives seek CEO opportunities: opportunity to make a contribution at their

hospital; to have the ability to influence and direct strategy; and something they always wanted to do (Parsons, Gustafson, Murray, & Dwore, 1997).

11. Primary factors contributing to command selection appear to be documented performance, experience, and service reputation.

Based on the target group survey results, the top three reasons (in order), why Navy Medical Department CAPTs are successfully screened for command include: performance, experience and service reputation. During the semi-structured interviews, the Surgeon General and Corps Chiefs/Directors (the command screening board), overwhelming responded with performance as the number one key factor. Their second and third reasons varied between experience, variety of assignments, service reputation, prior/current COs, and fitness report breakout/recommendation.

12. Medical Department Captains desire more information regarding the command screening process.

Sixty percent of the respondents in the target group survey stated that they were familiar with the command screening process. Of that group, knowledge deficiencies were uncovered in the following areas: who serves on the command screening board; who briefs their record at the command screening board; and the length of time individuals remain in the screened pool. Common themes uncovered in the target group survey's comment section include: process clarification; marketing and education; and defined career path.

13. Officers may not be screened early enough in their careers.

Eighty-five percent of the respondents in the target group survey believed that Navy Medicine should screen officers earlier in their careers. The respondents listed CDR and LCDR as the ranks for which command screening should begin.

B. RECOMMENDATIONS

1. Distribute increasingly clear direction on the command screening process, particularly to the target group and junior officers.

Increasingly educate the future leaders of Navy MTFs and DTFs on the process by which they are screened and selected for command. There are many communications media available to Navy Medical Department officers including web-based technology, assignment officer/detailer briefs, CD-ROM, and electronic mail. The move from Corps Chiefs/Director's community newsletters (paper) to web-based media, places increased responsibility on individual officers to obtain career information, including the command screening process. In short, relying on web-based technology may be insufficient in terms of providing thorough communications to all medical and dental officers. Information on the command screening process should be made available through several media sources. For example, the Director of the Medical Service Corps recently e-mailed a slide presentation and information on the command screening process to officers in the field, and the Meteorology/Oceanography community publishes a one-page summary document describing their screening and selection process.

Information covering the command screening process is usually published before the formal board is held in September. In reviewing BUMED's web pages, as well as the web pages of each of the four Corps Chiefs, there was no link available to obtain information on the command screening process. A permanent link should be established on the BUMED and Corps Chief's/Director's web pages with standardized information regarding the command screening process. The Medical Department assignment officers offer a slide presentation when traveling to different commands. There are two slides

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containing limited information on the command screening process. This slide presentation should be updated to include a more detailed description of the process, as well as current Navy Medicine policies regarding the process. A similar slide presentation covering the Medical Department command screening process should be made available to commands for COs, XOs, or other senior officers to use in mentoring junior officers. Corps Chiefs/Directors should include command screening process information in their presentations when visiting commands.

The Medical Department Officer Career Guide is currently under revision. The guide has some valuable information covering the command screening process including career pathways to command. The new updated guide should be published on the web and a CD-ROM version made available to each command where Navy Medical Department officers are assigned.

2.   Identify potential CO/XO candidates earlier in officers' careers.

Navy Medicine should not wait until Medical Department officers attain the rank of CAPT to determine if they have the skills and competencies required to take command. Officers should be identified for command earlier in their careers, and they should be given the opportunity to acquire the necessary skills and competencies needed. Officers interested in command at the CDR level should be tracked and coached to ensure they obtain needed skills and competencies.

3.   Ensure that fitness reports more accurately reflect officer's   .   performance, specifically officers eligible for command screening.

Navy Medicine selects the "best qualified" officers based primarily on the officer's service record. Performance is documented in an officer's fitness reports, and

as such, selection board members must rely on the reporting senior's accuracy in describing an officer's performance and potential for command. Occasionally, officers selected for command may not perform effectively. Questions lead to the selection process where officers with the best records are selected. It is imperative that reporting seniors know how to write good fitness reports, and express truthfully an individual's potential for command. Good and accurate fitness reports will reflect an officer's performance better and increase the validity of the fitness report in the command screening process.

4. **Standardize the initial stage of the command screening process among the four corps in Navy Medicine.**

Each Corps Chief's/Director's office distributes and collects the command screening survey in a different manner. The degree of involvement of assignment officers in this process varies among Corps. This may appear confusing to the target group. The Corps Chief's/Director's offices have made great strides in standardizing the survey form. Process standardization removes ill fillings, delineates a clear approach to the process, and eliminates any ambiguity among individuals, or groups affected by the process.

5. **Future Studies**

This study described and analyzed the Navy Medical Department command screening process because the formal process is relatively new (eleven years). The study determined that the overall process appears efficient, effective, and objective with some areas for improvement. There are several areas that could be studied in order to continually assess, compare, and improve this important process:

- Compare the life cycles of MTF COs (set three-year tenures) with civilian sector counterparts to determine strength and weaknesses of the different structures.

- Compare and contrast the similarities and differences of the command screening process among the three services, and analyze the costs and benefits of conjoining the process for DoD.

- Compile exit survey information from COs/XOs to assess the process from a post-command perspective.

- Develop a predictive, quantitative model pinpointing factors affecting command selection, i.e., demographic, performance, and skill sets.

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Personal interview with Special Assistant to the Director, Detailing Division (PERS-4412R), Supply Assignment/Placement Branch and Lieutenant Shore Detailer (PERS-4412I), Supply Assignment/Placement Branch on Thursday, 28 September 2000 at 0800 at the Naval Personnel Command, Millington, TN.

Personal interview with Special Assistant for Selection Board Matters (PERS-451F) on Thursday, 28 September 2000 at 0900 at the Naval Personnel Command, Millington, TN.

Personal interview with Head, Aviation LCDR/Junior Officer Assignments Branch (PERS-432) on Thursday, 28 September 2000 at 1100 at the Naval Personnel Command, Millington, TN.

Personal interview with Head, Surface Ship Placement Branch (PERS-413) and Community Management, Surface Officer Distribution Division (PERS-41M) on Thursday, 28 September 2000 at 1200 at the Naval Personnel Command, Millington, TN.

Personal interview with Director Submarine/Nuclear Power/CAPT Detailer Division (PERS-42) on Thursday, 28 September 2000 at 1300 at the Naval Personnel Command, Millington, TN.

Personal interview with Head, Oceanography Assignments/ Placement Branch (PERS-449) on Thursday, 28 September 2000 at 1400 at the Naval Personnel Command, Millington, TN.

Personal interview with Assistant Head/LCDR Detailer, Civil Engineering Corps Assignments/Placement Branch (PERS-4413A) on Thursday, 28 September 2000 at 1500 at the Naval Personnel Command, Millington, TN.

Personal interview with Head, Judge Advocate General Corps Assignments/Placement Branch (PERS-4416) on Thursday, 28 September 2000 at 1600 at the Naval Personnel Command, Millington, TN.

Personal interview with Head Dental Corps Assignments (PERS-4415G) on Friday, 29 September 2000 at 0800 at the Naval Personnel Command, Millington, TN.

Personal interview with Head Fleet Support Assignments Branch (PERS-4419) on Friday, 29 September 2000 at 0900 at the Naval Personnel Command, Millington, TN.

Personal interview with Chief, Navy Dental Corps (MED-00DC) and Deputy Chief, Navy Dental Corps (MED-00DCB) on Monday, 11 December 2000 at 0800 at the Navy Bureau of Medicine and Surgery, Washington, DC.

Personal interview with Director, Navy Nurse Corps (MED–00NC) on Monday, 11December 2000 at 1130 at the National Naval Medical Center, Bethesda, MD.

Personal interview with Navy Surgeon General/Chief, BUMED (OPNAV-09/MED-00) on Monday, 11December 2000 at 1330 at the Navy Bureau of Medicine and Surgery, Washington, DC.

Personal interview with Chief, Navy Medical Corps (MED–00MC) on Monday, 11 December 2000 at 1530 at the Navy Bureau of Medicine and Surgery, Washington, DC.

Personal interview with Deputy Director, Navy Nurse Corps (MED–00NCB) on Wednesday, 13 December 2000 at 0900 at the Navy Bureau of Medicine and Surgery, Washington, DC.

Personal interview with Medical Service Corps Career Planning Officer (MED-00MSCB1) on Wednesday, 13 December 2000 at 1030 at the Navy Bureau of Medicine and Surgery, Washington, DC.

Personal interview with Medical Corps Career Planning Officer (MED– 00MCB4) on Wednesday, 13 December 2000 at 1030 at the Navy Bureau of Medicine and Surgery, Washington, DC.

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Telephone interview with Director, Navy Medical Service Corps (MED–00MSC) on Monday, 18 December 2000 at 1130 at the Navy Bureau of Medicine and Surgery, Washington, DC.

APPENDIX A. TARGET GROUP QUESTIONNAIRE

NAVY MEDICAL DEPARTMENT
COMMAND SCREENING PROCESS VOLUNTARY SURVEY

Please complete ALL questions below by placing an "X" in the box that BEST describes you and your knowledge of the CURRENT process that Navy Medicine uses to select Medical Department officers during the annual Commanding Officer/Executive Officer Command Screening Board. Questions 13-15 require ranking (1, 2, 3) your top three responses. Your responses will be anonymous. The survey results will be used in a graduate education thesis at the Naval Postgraduate School. Please fax your completed survey to (831) 656-1098, Attn: LCDR Stevenson,MSC,USN by 31 Dec 00. Thank you!

Medical Corps ☐   Nurse Corps ☐   Dental Corps ☐
Medical Service Corps: Health Care Administration ☐ / Health Care Sciences ☐

Years of Service: ☐   Gender: Male ☐ / Female ☐

Race: White/Non Hispanic ☐   African American ☐   Asian ☐   Hispanic ☐   Other ☐

Prior/Current CO Tour: Yes ☐   No ☐
Prior/Current XO Tour: Yes ☐   No ☐

Prior/Currently CO Screened: Yes ☐   No ☐   Unsure ☐
Prior/Currently XO Screened: Yes ☐   No ☐   Unsure ☐

Did you receive a Command Screening Questionnaire in FY00? Yes ☐ No ☐ N/A ☐ Unsure ☐

Have you received a Command Screening Questionnaire every year since you have been a CAPT or CAPT select? Yes ☐ No ☐ N/A ☐ Unsure ☐

---

1. I am very familiar with the Medical Department Command Screening process.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

2. I know which medical department officers serve on the Command Screening Board.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

3. The person who briefs the record during the Command Screening Board is instrumental to an individual's selection.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

4. Which individual(s) brief your record during the Medical Department Command Screening Board?
Surgeon General ☐   Career Planner ☐   Specialty Leader ☐   Corps Chief ☐
          Detailer ☐   Current/Prior COs/XOs ☐   Other CAPTs ☐   Unsure ☐

5. The briefing process is objective.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

6. I purposefully check the results of the Medical Department Command Screening Board each year.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

Continued on reverse...

07 Dec 00

7. Once screened, how long does an individual remain on the Command Screened list?
   1 year☐   2 years☐   3 years☐   4 years☐   5 years☐   Indefinite☐

8. Individuals selected for Command Screening are selected for CO/XO assignments at the same time.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree☐

9. Medical Department officers should be given the option of voluntarily withdrawing their name from the Command Screening Board.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

10. The Command Screening process differentiates between an *executive* medicine career versus a *clinical* medicine career.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

11. I am very involved in my executive medicine career path.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

12. Selection for CO/XO screening is career enhancing.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

13. Rank (1,2,3) the top three reasons *you* would seek selection for CO/XO positions (1=top reason):
   Personal Satisfaction ☐   Career Accomplishment/Milestone ☐
   Greater Responsibility ☐   New Experience ☐
   Improve Navy Medicine ☐   Prepare for Civilian Job ☐
   I Earned it ☐   Not Applicable ☐

14. Rank (1,2,3) the top three reasons why you think individuals are typically selected at the O/XO
Screening Board: Performance ☐   Variety of Assignments ☐   Service Reputation ☐
   Politics☐   Education Level ☐   Experience ☐
   Corps Affiliation ☐   Unsure ☐   Prior/Current COs/ Supervisors ☐

15. Rank (1,2,3) the three most influential stakeholders in the Medical Department Command Screening Process (1 = most important):
   Surgeon General ☐   Corps Chief ☐   Specialty Leader☐   Detailer ☐
   Prior/Current COs ☐   Placement Officer ☐   Individual Member ☐   Unsure ☐

16. Navy Medicine effectively prepares junior officers for future assignments as COs/XOs.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree ☐

17. At which grade should Navy Medicine identify potential future COs/XOs for Medical/Dental Treatment Facilities?   LT/03☐   LCDR/04☐   CDR/05☐   CAPT/06☐

18. The Command Screening Process is fair.
Strongly Agree ☐   Agree ☐   Unsure ☐   Disagree ☐   Strongly Disagree☐

19. What part(s) of the Medical Department Command Screening process can be improved?
_____
_____
_____
_____
_____

07 Dec 00

END OF SURVEY...Thank you for participating!

APPENDIX B. INTERVIEW PROTOCOL – NAVPERSCOM

1. Does your community have a formal CO/XO screening board process?

2. Is CO/XO screening selection done together or separate?

3. Who owns the process?

4. How do politics play a role in the process?

5. How many COs/XOs do you select per year? (both screening, if applicable and assignments)

6. How many CO/XO billets are in your community? What is the rank structure for these types of billets?

7. Describe your community's career progression to CO/XO.

8. Does a member in your community have a choice whether or not they want to be screened/assigned CO/XO?

9. If a member turns down a CO/XO assignment, what is the impact to that individual's career?

10. If your community has a formal board, describe the board membership?

11. Describe your community's CO/XO screening/selection process?

12. Any special pays/benefits for COs/XOs in your community?

13. What happens to individuals in your community who fail CO/XO screening?

14. What is/are the biggest impacts whether an individual is CO/XO screened, or selected for a CO/XO assignment in your community?

15. Rank, in order of importance, the following as they impact CO/XO screening/ selection in your community: Politics, Previous Assignments, Educational Attainment, FITREPS, Service Reputation, Performance.

16. Describe the strengths and weaknesses of your community's CO/XO screening and selection process.

17. Describe your community's types of CO/XO assignments, level of responsibility and span of control.

18. Are individual's selected for CO/XO assignments in your community provided any special training prior to assuming command?

19. What is the length of tour for COs/XOs in your community?

20. Can an individual in your community complete back-to-back CO/XO assignments?

APPENDIX C. INTERVIEW PROTOCOL - BUMED

GENERAL BOARD QUESTIONS

Question 1 How important is the Navy Medicine command screening process on a scale from one to ten (ten being most important)?

Question 2 Do you think screening for CO/XO was career enhancing?

Question 3 How is the Command Screening process tied into Navy Medicine's Strategic Plan?

Question 4 What kind of turnover did you get on the Command Screening process from your predecessor?

POLICY DECISION MAKING QUESTIONS

Question 5 How are policy changes/decisions made regarding this process?

Question 6 Are you a decision maker or influencer and where does the Council of Corps Chiefs fall into the grouping of people?

Question 7 What are your roles and responsibilities in the process to your Corps...to Navy Medicine, as a member of the Council of Corps?

Question 8 During our research, we found very little written information about the board process and policies. Why?

Question 9 Once screened, how long does an individual remain on the Command Screened list?

Question 10 Will everyone who is screened get either a CO/XO position?

BOARD PROCESS QUESTIONS

Question 11 Does it hurt your career not to be screened?

Question 12 Before the formal command screening board was instituted in/about 1989, what was the process for selecting COs/XOs?

Question 13 How much time (in percentage) do you spend on the command screening process (survey distribution, board preparation, approving slate, etc.) per month?

Question 14 How does Navy experience/years of service impact the selection process (CAPTs range from 16 years for MC to 22 years of service for MSC and NC?

Question 15 From our research, we learned that Navy Medicine Command Screening Board is the only board held at NPC that, by SECNAV approval, can use the same members each year. Why?

TARGET GROUP QUESTIONS

Question 16 How is the Command Screening process and changes to the process communicated to the target group?

Question 17 From our research, we found that some of the CAPTs say there is not enough information available about the process. How do you view the effectiveness of current communication regarding the process?

Question 18 Another thing we have been finding is that many CAPTs feel Navy Medicine should be identifying potential CO/XO's sooner in their career specifically at the Commander (0-5) level similar to other Navy line and staff communities. Agree/Disagree?

FINAL QUESTIONS

Question 19 How do you know and/or measure if you selected the "Best Qualified?"

Question 20 What do you foresee as future changes to the process/policies/marketing?

MEDICAL CORPS CAREER PLANNING CHART

GRADE	YEARS	PHASE	ADMINISTRATIVE / 2XXX	CLINICAL (CONUS/OCONUS)	OPERATIONAL	EDUCATION/ ACADEMIC	RESEARCH
FLAG	25-30	EXECUTIVE	1A Surgeon General*; 2A Deputy Surgeon General; 4A Assistant Chief BUMED; 4B Deputy Asst SECDEF (HA); 6A CO Big-4*; 8A Staff, JCS/MED IG		3A Command Surgeon; 5A Fleet Surgeon; 8B Medical Officer of USMC	7A Dean USUHS	
CAPT	17-24	SENIOR	9A CO Naval Hospital (NH) - Large; 10A XO Big-4; 11A CO NH - Small; 12A Specialty Advisor; 13A XO NH - Large; 17A Staff (BUMED, OPNAV, BUPERS) DUINS (Service School)	(See Education/ Academic Track)	9B CO NEHC; 11B Director Medical Programs CMC/Division Chief BUMED; 12B Force Medical Officer FMFLANT/PAC; 14A MEF Surgeon; 15A Force Medical n* FLT; 15B Division FSSG Surgeon; 15C Wing Surgeon; 16A Force Medical Officer (AIR/SUB/SURF)LANT/PAC	9C CO HSETC; 13B XO HSETC; 14B Director Big-4; 15D Professor USUHS; 16B Dept Head Big-4; 17B Director FP-5	9D CO NMRDC/NAMI; 11C CO Lab; 14C CO NAMRU/EPMU; 17C XO NMRDC/NHRC/NAMRI; 17D XO NAMI
CDR	10-16	ADVANCED	19A CO/OIC Clinic; OIC Fleet Surgeon TM; 20A XO HH - Small	18A Director LMTF; 21 A Director MMTF; 24A Director SMTF/Dept Head LMTF; 25A Dept Head MMTF	18B Director NEHC; 22A SMO CV/CVN; 23A Dept Head NAMI/NEHC; Brigade Surgeon; 25B Dept Head EPMU	18C Dept Head FP-5/OIC NUMI; 22B Associate Professor USUHS; 24B Deputy Dept Head Big-4	18D Director NAMI; 21B XO NAMRU/EPMU; 24C Dept Head NUM; 24D Program Manage
LCDR	4-9	INTERMEDIATE		27A Deputy Dept Head LMTF/MMTF; 28A Dept Head SMTF (Board Certification GME-2+)	27B Regimental Surgeon / OPS FLT staff DUINS (Service School) (Board Certification GME-2+)	26A Deputy DHFP-5; Assistant Professor USUHS; (Board Certification GME-2+)	
LT	1-3	BASIC		GMO Utilization	29A OPS Utilization/Dept Head Afloat/Battalion Surgeon (GME-1)		

MEDICAL SCHOOL

* Medical Officer Required

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APPENDIX E. DENTAL CORPS CAREER PLANNING CHART

DENTAL CORPS CAREER PLANNING CHART

GRADE	YEARS	PHASE	ADMINISTRATIVE/ 2XXX	CLINICAL (CONUS/OCONUS)	OPERATIONAL	EDUCATION/ ACADEMIC	RESEARCH
FLAG	24-30	EXECUTIVE	1A Assistant Chief for Dentistry and Chief, Navy Dental Corps		2A Fleet Dental Officer (FDO)		
		EXECUTIVE	3A Deputy Assistant Chief for Dentistry; 3B Special Assistant to Chief, Navy Dental Corps; 3C Dental Advisor, CNET; 3D Executive Assistant to FDO	3E CO (Major NDC)	3F Dental Officer of USMC		
CAPT	19-30	SENIOR	4A Staff (DOD, BUMED, HSO)		4B Force Dental Officer (USMC)		
		SENIOR		5A CO 6A XO	5B CO (BN); 6B CO (DENCO); 6C Force Dental Officer (SUR/AIR/SUB/MCB)	6D OIC (SDAT); 6E Director (NDS)	5C CO (NDRI); 6F XO (NDRI)*
		SENIOR	7A Staff (BUMED, HSETC, BUPERS); DUINS (Service School)	7B Director of Clinical Services; 7C Director Dental Services (NH); 8A Branch Director / OIC / Dept Head	7D XO (DENCO)	7E Specialty Advisor; 8B Training Dept Head	
CDR	13-18	ADVANCED	9A Staff (BUMED, BUPERS)	9B Director of Clinical Services; 9C Director of Dental Services (NH); 10A Branch Director / OIC / Dept Head	10B Dept Head (Afloat)		10C Director (NDR
LCDR	7-12	INTERMEDIATE		11A Branch Director / OIC / Dept Head; 11B Director of Dental Services (NH); DUINS (ACP/Residency)	11C OIC (USMC); 11D Dept Head (Afloat/USMC); DUINS (Service School)		
LT	1-6	BASIC		12A Annex Branch Director; 12B Division Officer / Dept Head; DUINS (GPR)	12C Division Officer / DENOFF (MCB/USMC); 12D Division Officer / Dept Head (Afloat)		

DENTAL SCHOOL

NOTE: These positions may vary vertically on the grid and encompass different levels. Some actual positions within a given critical billet category may be at a higher level, others at a lower level, particularly where slashes (/) are involved. True comparability can only be established by examination and comparison of the individual jobs.

* Proposed

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APPENDIX F. MEDICAL SERVICE CORPS CAREER PLANNING CHART

MEDICAL SERVICE CORPS CAREER PLANNING CHART

GRADE	YEARS	PHASE	ADMINISTRATIVE / 2XXX	CLINICAL (CONUS/OCONUS)	OPERATIONAL	RESEARCH
FLAG	24-30	EXECUTIVE	1A Director, Medical Service Corps / Assistant Chief, BUMED			
CAPT	22-30	SENIOR	2A CO 3A XO 4A OIC 4B Director, Administration 5A Dept Head 5B HQ Directors 5c co	2B CO 5D Dept Head	2c co 3B XO 4c OIC 5E HQ Major Staff 5F HQ Staff	2DC0 3c XO 5G Research Management
CDR	16-22	ADVANCED	6A XO 7A OIC 8A Director Administration 9A Administrative Officer 9B Dept Head 9C HQ Staff	6B XO 9D Dept Head 9E Asst Dept Head	6C XO 7B OIC 8B HQ Major Staff 9F HQ Staff	6DC0 7c XO 9G Research Management
LCDR	6-16	INTERMEDIATE	10A OIC 11A Dept Head 12A HQ Staff 13A Dept Head *DUINS*	11B Dept Head 13B Dept Head *DUINS*	10B XO 11C Staff 13C Company Commander	13D Research Management *DUINS*
INS- LT	1 - 10	BASIC	14A Asst Dept Head	14B Asst Dept Head 14C Asst Dept Head	14D Staff	14E Specialty Tour

PROFESSIONAL SCHOOL

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APPENDIX G. NURSE CORPS CAREER PLANNING CHART

NURSE CORPS CAREER PLANNING CHART

GRADE	YEARS	PHASE	ADMINISTRATIVE/ 2XXX	NURSING PRACTICE/ ADMINISTRATION	EDUCATION
FLAG	27 - 30	EXECUTIVE	1A Director, Navy Nurse Corps		
	22-30	EXECUTIVE	2A CO MTF / 2B XO LMTF	2C NDW staff / 2D DNS LMTF	2E CO HSETC** / 2F CO NSHS **
CAPT	22-30	SENIOR	3A CO SMTF/MMTF	3B DNS MMTF/LMTF	3C XO HSETC** / 3D XO NSHS** / 3E Head Nursing Programs HSETC
			4A NDW Staff*/HSO Staff	4B NDW Staff"	
CDR	16-23	ADVANCED	5A XO SMTF/MMTF / 5B OIC MTF	5C DNS SMTF/MMTF / 5D ADNS LMTF	5E XO/OIC NSHS Detachment** / 5F Head CE&T LMTF** / 5G Dept Head HSETC** / 6B Head CE&T SMFT/MMFT** / 6C Dept Head NSHS Detachment**
				6A Nursing Service Dept Head	
			7A NDW Staff*/HSO Staff	7B NDW Staff*/HSO Staff	
LCDR	10 - 18	INTERMEDIATE	8A NDW Staff*/HSO Staff	8B NDW Staff*/HSO Staff	9B Head Nursing Education Division
			DUINS (Admin.)	9A Nursing Service Division Officer / DUINS (Clinical)	DUINS (ETMS)
ENS - LT	1 - 9	BASIC		10A Nursing Service Division Officer	10B Head Nursing Education Division
				11A Staff Nurse, MTF	

BASIC NURSING PREPARATION

* NDW Staff = The wide variety of Washington-area Headquarters (BUMED, BUPERS or Secretariat (ASD(HA)) assignments available to Nurse Corps officers.

** While these are actually 2XXX positions, they are shown in the education track to clarify career progression within this specialty.

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APPENDIX H. LIST OF 40 COMPETENCIES

Joint Medical Executive Skills Development Program		Professional Organizations Certifying Military Health System Officers[1]										
Seq. Nr.	Executive Skills Program Competencies (40)	AAMA	ACHE	ACPE1	ACPE2	ADA	AHIMA	ANCC	ASQ	HFMA	NCCPA	NAHQ
	Military Medical Readiness											
1	Medical Doctrine											
2	Understanding the Military Mission											
3	Joint Operations and Exercises											
4	Total Force Management											
5	NDMS Management/DVA Role											
6	Medical Readiness Training											
7	Contingency Planning											
	General Management											
8	Strategic Planning	X	X	X	X			X	X	X		X
9	Organizational Design	X		X	X					X		
10	Decision Making	X	X	X	X			X		X	X	
11	Personal and Organizational Ethics	X	X					X				
12	Managing Change and Innovation	X	X	X	X							
13	Leadership	X	X					X	X			
	Health Law and Policy											
14	Public Law (General)	X	X				X	X		X		X
15	Public Law (International)											
16	Medical Liability							X		X	X	X
17	Medical Staff By-Laws		X									
18	Regulations	X	X									
19	External Accreditation						X	X		X		X
	Health Resources Allocation and Management											
20	Financial Management	X	X	X	X			X		X		X
21	Human Resources Management		X		X		X	X	X	X		X
22	Labor-Management Relations	X			X			X				
23	Materiel Management											X
24	Facilities Management		X									
25	Information Management	X	X		X			X		X		X
	Medical Ethics											
26	Patient Rights (Informed Consent)					X		X			X	
27	Patient Rights ("Right to Die"/DNR)							X				
	Individual and Organizational Behavior											
28	Individual Behavior				X	X	X	X	.		X	X
29	Group Dynamics			X	X			X			X	
30	Conflict Management			X	X		X	X	X			
31	Communication			X	X			X	X		X	
32	Public Speaking				X							
33	Public and Media Relations											
	Clinical Understanding											
34	Epidemiological Methods	X					X				X	X
35	Clinical Investigation	X						X				
36	Alternate Health Care Delivery Systems	X	X		X	X		X		X		X
	Performance Measurement											
37	Quality Management (TQM, TQL, QAF)	X	X		X		X	X	X	X		
38	Quantitative Analysis	X					X	X	X	X		X
39	Process/Outcome Measurement		X				X		X			X
40	Clinical Performance Improvement		X		X		X					X
	Number of Competencies Certified	16	16	8	16	4	11	19	9	11	6	15

[1]An X indicates the competency is tested by the certification examination.

ACPE1 is the Certificate in Medical Management (inclusive of PIM)

ACPE2 is the Certified Physician Executive (inclusive of PIM)

ANCC is the Certified Nurse Administrator

NAHQ certification is Certified Professional in Healthcare Quality

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APPENDIX I. NAVY MEDICAL DEPARTMENT OFFICER EXECUTIVE MEDICINE MATRIX

Navy Medical Department
Officer Executive Medicine Matrix

	MEDICAL/DENTAL TREATMENT FACILITIES	EDUCATION/ ACADEMIC	RESEARCH	OPERATIONAL	OTHERS
BILLETS Link BUMED Key Command	CO/XO Hospitals, Dental Facilities, Clinic Commands some NACCs	NSHS Bethesda-CO/XO NSHS San Diego-CO/XO NSHS- Portsmouth-CO/XO NH Corps School-CO/XO BUMED- Various staff positions Dir., Naval Dental Postgrad School Flt. Medical Service School NSHS-various staff positions	NMRC-CO/XO NHRC-CO/XO NAMRU-2 & 3-CO/XO NSMRL-CO/XO NAMRL-CO/XO NDRI-CO/XO NHRC-EMRDET-OIC NMRCDET-OIC NHRC-TOXDET-OIC	Director, Med. Programs USMC TYCOMS, MARFORS, MEFS Numbered Flt.Surgeons/Dentists CINCUSNAVEUR, CNSRF NORLEANS, JAWP CNRF, CNARF Fleet Hospitals Hospital Ships	NMLC-CO/XO, NEHC-CO/XO, NOMI-CO/XO EPMU, NMIMC NOSTRA HSO-OIC OP-093-staff BUMED -staff Lead Agent-Director Navy IG, OSD Staff DVECC
EDUCATION Link NSHS Courses	SMRCC, Interagency Institute, MHS Capstone, Senior Officer Course in Military Justice, Senior Officer Leadership Training Continuum Graduate management education Service Colleges CO/XO Shore Station Course	Masters In Education, SMRCC, Interagency Institute, Senior Officer Course In Military Justice, Senior Officer Leadership Training Continuum Instructor experience CO/XO Shore Station Course	PhD In research field, SMRCC, Interagency Institute, Senior Officer Course In Military Justice, Senior Officer Leadership Training Continuum Graduate mgmt education CO/XO Shore Station Course	Operational Medicine Courses, Service Colleges SMRCC, Senior Officer Course In Military Justice, Senior Officer Leadership Training Continuum Combat Casulty 4 (Alpha) Joint Medical Planners Course CO/XO Shore Station Course	SMRCC, Interagency Institute, MHS Capstone, Senior Officer Course In Military Justice, Senior Officer Leadership Training Continuum CATF Surgeon CO/XO Shore Station Course
EXPERIENCE	Directors at MTF OIC of large branch clinics Branch Directors of dental clinics Dept. Hds of Large complex depts. BUMED/TRICARE/PERS and other similar staff positions	Residency/program director, Specialty Leader, Dept Hd In teaching facilities, Dir. GME, Dept Hd NSHS, Dept Hd Educ In large teaching facilities	Dept Hd at Research Commands Research assignments, Tour at N-931, N911, BUMED, or ONR,	FMF, SMO, SMDO, SNO MAO, Med/Den Bn Flt Surgical Team Component or Unified commands	Variety of levels of rsponsibility within medical, research facilities EPMU
COMPETENCIES Link NSHS EME	Evaluate which of the 40 EME Competencies you've met: link to NSHS Executive Medicine Competencies Active Professional Affiliation	Evaluate which of the 40 EME Competencies you've met: link to NSHS Executive Medicine Competencies Active Professional Affiliation	Evaluate which of the 40 EME Competencies you've met: link to NSHS Executive Medicine Competencies Active Professional Affiliation	Evaluate which of the 40 EME Competencies you've met: link to NSHS Executive Medicine Competencies Active Professional Affiliation	Evaluate which of the 40 EME Competencies you've met: link to NSHS Executive Medicine Competencies Active Professional Affiliation

Note: These pathways are designed to offer guidance and do not imply exclusivity.

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APPENDIX J. FY-01 CO/XO SCREENING SURVEY

FY-01 CO/XO SCREENING SURVEY

Name: _____ E-mail: _____ Corps:_____

PLEASE PRINT OR TYPE ALL ANSWERS SO THEY CAN BE EASILY READ. THANK YOU.

DO YOU WISH TO BE SCREENED FOR CO/XO?	YES	NO (Not at this time)	
ARE YOU UNIVERSALLY ASSIGNABLE?	YES	NO (If no, please explain)	
DO YOU WANT THIS FORM SENT IN FUTURE YEARS?		YES	NO

Please list previous leadership assignments with dates and location (i.e. CO/XO/OIC/Director)

POSITION	DATES	LOCATION

Please list formal courses (military or civilian) in Administration and/or management, including dates, institution and location (e.g. Executive Medical Management, Sep 91, U of MD, Baltimore MD).

COURSE	DATE	INSTITUTION	LOCATION

Please list leadership/management-related certification(s) or degree(s):

CERTIFICATION OR DEGREE	GRANTING ORGANIZATION/INSTITUTION

<u>For all: Please return this form indicating your desire for CO/XO screening.</u> If you wish your record to be screened, also include a copy of your curriculum vitae (CV) and biographical sketch with this form and return to: Chief, Bureau of Medicine and Surgery (Code 00NCB, 00MCB, 00MSCB or 00DCB as applicable), 2300 E Street, NW, Washington DC 20372-5300. Or you may fax the completed form with your CV and bio to the applicable Corps Chief at the following numbers:

Code 00NCB: (202)-762-3727	Code 00MSCB (202)-762-1730
Code 00MCB: (202)-762-1626	Code 00DCB: (202)-762-3023

NOTE: If faxing your return please be sure to include a cover sheet with the number of pages faxed so we can be sure all have been received – Thank you!

Do you wish to receive an email confirmation regarding our receipt of your response? (Circle applicable response): YES/NO

Signature   Date

Rev: 5/15/00

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    Monterey, CA 93943-5121

4. Professor Cary A. Simon, Code SM/Sn............................2
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    2300 E Street, NW
    Washington, DC 20372-5300

8. Naval Personnel Command..1
    PERS-4415I
    5720 Integrity Drive
    Millington, TN 38055-0000

9.   LCDR Mark J. Stevenson, MSC, USN...................................2
12612 Heritage Farm Lane
Oak Hill, VA 20171

10.   LT Chad E, Roe, MSC, USN...2
1423 Cambridge Drive
South Bend, IN 46614